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RILEY C. DARNELL
Secretary of State

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PREFACE

The Tennessee Administrative Register (T.A.R.) is an official publication of the Tennessee Department of State. The *T.A.R.* is compiled and published monthly by the Department of State pursuant to *Tennessee Code Annotated, Title 4, Chapter 5*. The *T.A.R.* contains in their entirety or in summary form the following: (1) various announcements (e.g. the maximum effective rate of interest on home loans as set by the Department of Commerce and Insurance, formula rate of interest and notices of review cycles); (2) emergency rules; (3) proposed rules; (4) public necessity rules; (5) notices of rulemaking hearings and (6) proclamations of the Wildlife Resources Commission.

Emergency Rules are rules promulgated due to an immediate danger to the public health, safety or welfare. These rules are effective immediately on the date of filing and remain in effect thereafter for up to 165 days. Unless the rule is promulgated in some permanent form, it will expire after the 165-day period. The text or a summary of the emergency rule will be published in the next issue of the *T.A.R.* after the rule is filed. Thereafter, a list of emergency rules currently in effect will be published.

Proposed Rules are those rules the agency is promulgating in permanent form in the absence of a rulemaking hearing. Unless a rulemaking hearing is requested within 30 days of the date the proposed rule is published in the *T.A.R.*, the rule will become effective 105 days after said publication date. All rules filed in one month will be published in the *T.A.R.* of the following month.

Public Necessity Rules are promulgated to delay the effective date of another rule that is not yet effective, to satisfy constitutional requirements or court orders, or to avoid loss of federal programs or funds. Upon filing, these rules are effective for a period of 165 days. The text or summary of the public necessity rule will be published in the next issue of the *T.A.R.* Thereafter, a list of public necessity rules currently in effect will be published.

Once a rule becomes effective, it is published in its entirety in the *official compilation-Rules and Regulations of the State of Tennessee*. Replacement pages for the compilation are published on a monthly basis as new rules or changes in existing rules become effective.

Wildlife Proclamations contain seasons, creel, size and bag limits, and areas open to hunting and/or fishing. They also establish wildlife and/or public hunting areas and declare the manner and means of taking. Since Wildlife Proclamations are published in their entirety in the *T.A.R.*, they are not published in the *official compilation-Rules and Regulations of the State of Tennessee*.

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ANNOUNCEMENTS

OFFICE OF THE ATTORNEY GENERAL OF THE STATE OF TENNESSEE

ATTORNEY GENERAL'S GUIDELINES FOR EVALUATION OF PROPOSED REGULATORY OR ADMINISTRATIVE ACTIONS TO AVOID UNCONSTITUTIONAL TAKINGS OF PRIVATE PROPERTY

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I. PURPOSE

These guidelines are submitted by the Office of the Attorney General pursuant to Chapter 924 of the Public Acts of 1994 (codified at T.C.A. § 12-1-201, et seq.). Section 4 of the Act requires the Attorney General to develop guidelines to assist state agencies in the identification and evaluation of government actions that may result in an unconstitutional taking of private property, in order to avoid an unnecessary burden on the public treasury and unwarranted interference with private property rights. The guidelines establish a basic framework for agencies to use in their internal evaluations of the takings implications of administrative and regulatory policies and actions. The guidelines do not prevent an agency from making an independent decision about proceeding with a specific policy or action which the decisionmaker determines is authorized by law.

These guidelines are intended solely as internal and predecisional management aids for agency decisionmakers and should not be construed as an opinion by the Attorney General on whether a specific action constitutes a taking. A private party shall not be deemed to have a cause of action against an agency for failure to follow any suggested procedures contained in the guidelines.

II. SCOPE

An agency should evaluate, for their takings implications, its administrative and regulatory policies and actions that affect, or may affect, the use or value of private real property in accordance

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with the framework established in these guidelines, including, but not limited to, regulations that propose or implement licensing, permitting or certification requirements, conditions or restrictions otherwise imposed by an agency on private property use, and any actions relating to or causing the physical occupancy or invasion of private property. These guidelines are limited to examination of takings of private real property and are not intended to govern or affect issues such as validity of searches or investigative or discovery demands which are controlled by other statutory and constitutional law.

The following policies and actions are excluded from evaluation under these guidelines:

1. The exercise of the power of eminent domain;
2. The forfeiture or seizure of private property by law enforcement agencies as evidence of a crime or for violations of law;
3. Orders issued by a state agency or court of law that result from a violation of law and that are authorized by statute; and
4. The discontinuation of government programs.

Examples of agency actions that would be excluded under these guidelines include, but are not limited to, tax enforcement and collection activities pursuant to T.C.A. § 67-1-1401, et seq, or other authority.

III. GENERAL PRINCIPLES

A. Constitutional and Statutory Framework

The Fifth Amendment to the United States Constitution provides that private property shall not be taken for public use without just compensation. Article 1, Section 21 of the Tennessee Constitution provides that “[n]o man’s particular services shall be demanded, or property taken, or applied to public use, . . . without just compensation. . . .” The government may not, therefore, take property except for public purposes within its constitutional authority and only upon payment of just compensation.

The State has historically used its power of eminent domain under T.C.A. § 29-16-101, et seq. to acquire private property for a public purpose, such as a highway or recreation area, and in so doing has compensated property owners through a formal condemnation proceeding. The government, however, may also become liable for payment of just compensation to private property owners without the initiation of formal proceedings, when private property has either been physically occupied or invaded by the government on a permanent or temporary basis, or so affected by governmental regulation as to have been effectively taken despite the fact the government has neither physically invaded, confiscated nor occupied the property. In contrast to the formal exercise of eminent domain, the private property owner can obtain compensation by filing an “inverse condemnation” suit.

B. Nature of a Taking

A taking of private property rights may occur when permanent or temporary government actions result in the physical occupancy of property, the physical invasion of property, either directly or indirectly (see discussion in B. 2. below), or the regulation of property.

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1. Physical Occupancy

As a general rule, a physical occupation of property by the government which is permanent is a taking, regardless of how slight the occupancy, the minimal economic impact on the property owner or whether the government action achieves an important public benefit. Aside from formal condemnation exercises, examples of physical occupancy takings include permanent utility easements and access easements. In some circumstances, however, even a temporary access easement may be deemed to be a physical taking. See discussion in B. 2. below.

2. Physical Invasion

The concept of permanent physical occupation does not necessarily require that in every instance the occupation be exclusive or continuous and uninterrupted. Physical invasions of property may also give rise to a taking where the invasions are of a recurring and substantial nature, or of finite duration, and thereby amount to temporary takings. Examples of physical invasion takings may include, among others, flooding and water related intrusions resulting from government projects, access easements, and aviation easement intrusions. The last example is not necessarily limited to direct overflights, but may result where there is continuous interference, through noise, pollution or vibration, with the beneficial use and enjoyment of property. Moreover, the government action that causes a physical invasion must result from some purposeful or intentional action for a taking to exist.

3. Regulatory Takings

Land use regulations that affect the value, use, or transfer of private property may constitute a taking if the regulations are adjudged to go too far. The greater the deprivation of use, the greater the likelihood that a taking will be found.

While there is no set formula for determining when government action constitutes a taking, an agency should consider the following criteria:

- a. Whether the regulation denies the landowner all economically viable use of his property or substantially interferes with his reasonable investment-backed expectations. In this regard, the timing of the regulatory enactment with respect to the landowner's acquisition of title may be relevant, but not necessarily dispositive.
- b. Whether the regulation is not reasonably related or roughly proportional to the projected impact of the landowner's proposed use of the property. Regulation of an individual's property that conditions approval of a permit/development on the dedication of some property to public use must not be disproportionate to the degree to which the individual's property use is contributing to the overall problem. The less direct, immediate and demonstrable the contribution of the property-related activity to the harm to be addressed, the greater the risk that a taking will be found.
- c. The degree to which a regulatory action closely resembles, or has the effect of, physical invasion or occupation of property. For example, an intended policy or action that totally abrogates an essential property interest, such as the right to exclude others by imposing an access easement, may, in certain circumstances, constitute a taking. See discussion in B. 2. above and C. 1. below.

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C. Special Situations and Suggested Procedures

When implementing a regulatory policy or action and evaluating the takings implications of that policy or action, agencies should consider the following special factors and suggested procedures:

1. Permitting and Certification Programs

The programs of many agencies require private parties to obtain permits or certification before making specific uses of, or acting with respect to, private property. An agency may place conditions on the granting of such permits or certification, or deny the same, without necessarily effecting a taking for which compensation is due, however, the agency should first consider the following factors in determining whether a taking may result:

- a. Whether the government action will deprive the owner of essentially all economically viable or productive use of his property (see discussion below in C. 2. regarding economic impact of regulation); and
- b. The degree to which the state imposed restriction interferes with the owner's reasonable investment-backed expectations; and
- c. Whether the condition imposed by the government will result in a permanent physical occupation or invasion of the property, such as an access easement; and
- d. Whether a condition that requires a dedication of property to public use is reasonably related or roughly proportional to the projected impact of the landowner's proposed use of the property. Where public health and safety is the asserted regulatory purpose, then the health and safety risk posed by the property use must be identified with as much specificity as possible and should be real and substantial, and not merely speculative.

2. Assessing Economic Impact of the Regulation as Applied

In assessing whether a proposed policy or action may effect a taking of private property, an agency may want to consider the economic impact of a regulation by examining the following factors:

- a. The character and present use of the property, as well as the character and anticipated duration of the proposed or intended government action; and
- b. The likely degree of economic impact on all identified property and economic interests. A mere diminution in the value of the property to be regulated by the government's denial of the highest and best use of the property will not generally, by itself, amount to a taking (but see discussion below in C. 3. regarding the "parcel as a whole"); and
- c. Whether the proposed policy or action carries benefits to the private property owner that offset or otherwise mitigate the adverse economic impact of the proposed policy or action; and
- d. Whether alternative actions are available that would achieve the underlying lawful governmental objective and would have a lesser economic impact.

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3. The "Parcel as a Whole" Analysis

In determining the economic impact of a proposed or intended government action, an agency should consider the impact on the "parcel as a whole," and not merely the part of the parcel that is subject to regulation. The parcel as a whole is not limited by its geographic dimensions, but also has a temporal aspect defined by the term of years of the owner's interest in the land. Generally, if an owner has been denied economic use of a segment of a parcel, but retains viable economic use of other segments of the same parcel, a taking may not result.

Paul G. Summers
Attorney General

July 19, 2005

(07-36)

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DEPARTMENT OF FINANCIAL INSTITUTIONS – 0180

ANNOUNCEMENT OF FORMULA RATE OF INTEREST

Pursuant to the provisions of Chapter 464, Public Acts of 1983, the Commissioner of Financial Institutions hereby announces that the formula rate of interest is 10.25%.

This announcement is placed in the Tennessee Administrative Register for the purpose of information only and does not constitute a rule within the meaning of the Uniform Administrative Procedures Act.

Kevin P. Lavender

DEPARTMENT OF FINANCIAL INSTITUTIONS – 0180

ANNOUNCEMENT OF MAXIMUM EFFECTIVE RATE OF INTEREST

The Federal National Mortgage Association has discontinued its free market auction system for commitments to purchase conventional home mortgages. Therefore, the Commissioner of Financial Institutions hereby announces that the maximum effective rate of interest per annum for home loans as set by the General Assembly in 1987, Public Chapter 291, for the month of September 2005 is 8.42 percent per annum.

The rate as set by the said law is an amount equal to four percentage points above the index of market yields of long-term government bonds adjusted to a thirty (30) year maturity by the U. S. Department of the Treasury. For the most recent weekly average statistical data available preceding the date of this announcement, the calculated rate is 4.42 percent.

Persons affected by the maximum effective rate of interest for home loans as set forth in this notice should consult legal counsel as to the effect of the Depository Institutions Deregulation and Monetary Control Act of 1980 (P.L. 96-221 as amended by P.L. 96-399) and regulations pursuant to that Act promulgated by the Federal Home Loan Bank Board. State usury laws as they relate to certain loans made after March 31, 1980, may be preempted by this Act.

Kevin P. Lavender

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GOVERNMENT OPERATIONS COMMITTEES

ANNOUNCEMENT OF PUBLIC HEARINGS

For the date, time, and, location of this hearing of the Joint Operations committees, call 615-741-3642. The following rules were filed in the Secretary of State's office during the previous month. All persons who wish to testify at the hearings or who wish to submit written statements on information for inclusion in the staff report on the rules should promptly notify Fred Standbrook, Suite G-3, War Memorial Building, Nashville, TN 37243-0059, (615) 741-3072.

ANNOUNCEMENTS

SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
07-01	July 1, 2005	1240 Human Services Family Assistance Division	Public Necessity Rules	Amendments	<i>Chapter 1240-1-50</i> <i>Financial Eligibility Requirements Families First Program</i> 1240-1-50-.20 Standard of Need/Income	Phyliss Simpson Citizens Plaza Bldg 15th Fl 400 Deaderick St Nashville Tn 37248-0006 313-6673	July 1, 2005 through Dec 13, 2005
07-02	July 1, 2005	1240 Human Services Child Support Division	Rulemaking Hearing Rules	Amendments	<i>Chapter 1240-2-3</i> <i>Miscellaneous IV-D</i> 1240-2-3-.02 Federal Tax Refund Intercept Program	Kim Beals Citizens Plaza Bldg 15th Fl 400 Deaderick St Nashville TN 37248-0006 313-4731	Sept 15, 2005
07-03	July 1, 2005	0620 Finance and Administration Bureau of TennCare	Public Necessity Rules	Amendments	<i>Chapter 1200-13-1</i> <i>General Rules</i> 1200-13-1-.03 Amount, Duration, and Scope of Assistance	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 507-6446	July 1, 2005 through Dec 13, 2005
07-04	July 1, 2005	0620 Finance and Administration Bureau of TennCare	Public Necessity Rules	Amendments	<i>Chapter 1200-13-13</i> <i>TennCare Medicaid</i> 1200-13-13-.04 Covered Services	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 507-6446	July 1, 2005 through Dec 13, 2005
07-05	July 1, 2005	0620 Finance and Administration Bureau of TennCare	Public Necessity Rules	Amendments	<i>Chapter 1200-13-13</i> <i>TennCare Medicaid</i> 1200-13-13-.05 Enrollee Cost Sharing	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 507-6446	July 1, 2005 through Dec 13, 2005
07-06	July 1, 2005	0620 Finance and Administration Bureau of TennCare	Public Necessity Rules	Amendments	<i>Chapter 1200-13-14</i> <i>TennCare Standard</i> 1200-13-14-.04 Covered Services	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 507-6446	July 1, 2005 through Dec 13, 2005
07-07	July 1, 2005	0620 Finance and Administration Bureau of TennCare	Public Necessity Rules	Amendments	<i>Chapter 1200-13-14</i> <i>TennCare Standard</i> 1200-13-14-.05 Enrollee Cost Sharing	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 507-6446	July 1, 2005 through Dec 13, 2005

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SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
07-08	July 6, 2005	0620 Finance and Administration Bureau of TennCare	Public Necessity Rules		<i>Chapter 1200-13-14 TennCare Standard</i> 1200-13-14-.12 Other Appeals By TennCare Applicants and Enrollees	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 507-6446	July 6, 2005 through Nov 20, 2005
07-09	July 6, 2005	0620 Finance and Administration Bureau of TennCare	Public Necessity Rules		<i>Chapter 1200-13-13 TennCare Medicaid</i> 1200-13-13-.12 Other Appeals By TennCare Applicants and Enrollees	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 507-6446	July 6, 2005 through Nov 20, 2005
07-11	July 12, 2005	1660 Wildlife Resources Agency	Rulemaking Hearing Rules	Amendments	<i>Chapter 1660-1-8 Rules and Regulations of Hunts</i> 1660-1-8-.03 Permit Requirements – Wildlife Management Areas And Refuges 1660-1-8-.05 Permit Applications and Drawings	Sheryl Holtam TWRA P.O. Box 40747 Nashville TN 37204 (615) 781-6606	Sept 25, 2005
07-12	July 12, 2005	1660 Wildlife Resources Agency	Rulemaking Hearing Rules	New Rule	<i>Chapter 1660-1-15 Animal Importation</i> 1660-1-15-.02 Importation of Wildlife Carcasses, Parts, and Products	Sheryl Holtam TWRA P.O. Box 40747 Nashville TN 37204 (615) 781-6606	Sept 25, 2005
07-13	July 13, 2005	0800 Labor and Workforce Development Workers' Compensation	Petition for Rulemaking Hearing		<i>Chapter 0800-2-18 Medical Fee Schedule</i> <i>Chapter 0800-2-17 Medical Cost Containment Program</i> <i>TN Medical Assoc.</i>		Sept 27, 2005
07-14	July 14, 2005	1220 Tennessee Regulatory Authority	Rulemaking Hearing Rules	New Rule	<i>Chapter 1220-4-1 General Public Utility Rules</i> 1220-4-1-.08 Name Changes for Public Utilities	J. Richard Collier General Counsel TRA 460 J Robertson Pkwy Nashville TN 37343 (615) 741-2904 ext 170	Sept 27, 2005
07-16	July 14, 2005	1200 Finance and Administration Bureau of TennCare	Rulemaking Hearing Rules	Amendment	<i>Chapter 1200-13-13 TennCare Medicaid</i> 1200-13-13-.01 Definitions	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 741-0145	Sept 27, 2005

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SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
07-17	July 14, 2005	0620 Finance and Administration Bureau of TennCare	Rulemaking Hearing Rules	Amendments	<i>Chapter 1200-13-14 TennCare Standard</i> 1200-13-14-.01 Definitions	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 741-0145	Sept 27, 2005
07-18	July 20, 2005	1200 Finance and Administration Bureau of TennCare	Rulemaking Hearing Rules	Amendment	<i>Chapter 1200-13-13 TennCare Medicaid</i> 1200-13-13-.01 Definitions	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 741-0145	Oct 3, 2005
07-19	July 20, 2005	0620 Finance and Administration Bureau of TennCare	Rulemaking Hearing Rules	Amendments	<i>Chapter 1200-13-14 TennCare Medicaid</i> 1200-13-14-.01 Definitions	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 741-0145	Oct 3, 2005
07-25	July 25, 2005	0080 Agriculture Division of Animal Industries	Emergency Rules	New RULE	<i>Chapter 0080-2-1 Health Requirements For Admission And Transportation Of Lifestock And Poultry</i> 0080-2-1-.17 Restrictions on Shipments From Known Vesicular Stomatitis States or Regions	Phyllis Childs Department of Agriculture P. O. Box 40627 Nashville, TN 37204 615-837-5280	July 25, 2005 through Jan 6, 2006

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SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
07-26	July 25, 2005	1040 State Oil and Gas Board	Rulemaking Hearing Rules	Amendments	<i>Chapter 1040-2-2 Through 1040-8-1</i> 1040-2-2-.02 Drilling Permits 1040-2-2-.04 Plug and Abandon Permit 1040-2-3-.01 Preparing Plats 1040-2-4-.01 Well Spacing 1040-2-5-.01 Posting a Sign 1040-2-7-.02 Surface Casing 1040-2-7-.03 Production Casing 1040-2-9-.01 Plugging Wells 1040-2-9-.02 Inspection 1040-2-9-.03 Deliverability Test 1040-3-1-.01 Time Limit For Well Completion 1040-3-1-.02 Application For Permit 1040-3-2-.02 Connections 1040-3-2-.04 Subsurface Safety Valves 1040-3-3-.01 Safety 1040-3-3-.02 Pollution and Safety Controls 1040-4-2-.02 Gauging 1040-4-3-.05 Monthly Reporting-Producers 1040-4-3-.06 Monthly Reporting-Transporters 1040-4-3-11 Monthly Reports-Gas 1040-7-1-.01 Report and Permit Forms 1040-8-1-.10 Method of Determinations	David L. Henry, OGC Environment & Conservation (615) 532-0131	Oct 8, 2005
				New Rule	<i>Chapter 1040-2-10</i> <i>Filing of Well Data, Reports and Maps</i> 1040-2-10-.06 Annual Well Report		
				Repeals	1040-2-2-.03 Multiple Completion Permit 1040-3-1-.08 Multiple Completions 1040-3-1-.09 Tubingless Completions 1040-3-2-.01 Tubing and Completion 1040-4-2-.09 Required Records 1040-4-2-.10 Reporting Wells Off Production 1040-4-2-.11 Computing Quantities 1040-4-2-.12 Combined Correction Tables 1040-4-3-.03 Authorization to Transport 1040-4-3-.04 Transporter's Connecting to Leases 1040-4-3-.07 Monthly Reporting-Storers		

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SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
07-32	July 26, 2005	0780 Commerce and Insurance Division of Insurance	Emergency Rules	New Rules	<i>Chapter 0780-1-88</i> <i>Tennessee Health Insurance Portability, Availability and Renewability Regulations</i> 0780-1-88-.01 Purpose and Scope 0780-1-88-.02 Definitions 0780-1-88-.03 Producer Compensation 0780-1-88-.04 Penalties 0780-1-88-.05 Severability	John F. Morris Commerce and Insurance 500 James Robertson Pkwy 5th Fl Davy Crockett Twr Nashville TN 37243 615-741-2199	July 26, 2005 through Jan 7, 2006
07-37	July 28, 2005	1200 Health Board for Licensing Health Care Facilities	Rulemaking Hearing Rules	Amendments	<i>Chapter 1200-8-1</i> <i>Standards for Hospitals</i> 1200-8-1-.07, Optional Hospital Services	Ernest Sykes, Jr. Asst. General Counsel Department of Health Office of General Counsel 26th Floor, Tennessee Tower 212 Eighth Avenue North Nashville, TN 37247-0120 615-532-7156	Oct 10, 2005
07-38	July 28, 2005	0620 Finance and Administration Bureau of TennCare	Rulemaking Hearing Rules	Amendments	Chapter 1200-13-14 TennCare Standard 1200-13-14-.01 Definitions 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 507-6446	Oct 11, 2005
07-39	July 28, 2005	0620 Finance and Administration Bureau of TennCare	Rulemaking Hearing Rules	Amendments	Chapter 1200-13-14 TennCare Standard 1200-13-14-.02 Eligibility	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 507-6446	Oct 11, 2005
07-40	July 28, 2005	0620 Finance and Administration Bureau of TennCare	Rulemaking Hearing Rules	Amendments	Chapter 1200-13-13 TennCare Medicaid 1200-13-13-.01 Definitions 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 507-6446	Oct 11, 2005

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SEQ. NO.	DATE FILED	DEPARTMENT AND DIVISION	TYPE OF FILING	DESCRIPTION	RULE NUMBER AND RULE TITLE	LEGAL CONTACT	EFFECTIVE DATE
07-41	July 28, 2005	0620 Finance and Administration Bureau of TennCare	Rulemaking Hearing Rules	Amendments	Chapter 1200-13-13 TennCare Medicaid 1200-13-13-.02 Eligibility 1200-13-13-.03 Enrollment, Disenrollment, Re-enrollment, and Reassignment	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 507-6446	Oct 11, 2005
07-42	July 29, 2005	1680 Tennessee Wildlife Resources Agency	Rulemaking Hearing Rules	Amendment	Chapter 1660-1-28 Rules and Regulations Governing Licenses, Permits and Fees 1660-1-28-.04 Miscellaneous Licenses, Permits and Fees	Sheryl Holtam TWRA P.O. Box 40747 Nashville TN 37204 (615) 781-6606	Oct 12, 2005
07-43	July 29, 2005	0620 Finance and Administration Bureau of TennCare	Public Necessity Rules	Amendment.	Chapter 1200-13-13 TennCare Medicaid 1200-13-13-.08 Providers	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 507-6446	July 29, 2005 through Jan 10 , 2006
07-44	July 29, 2005	0620 Finance and Administration Bureau of TennCare	Public Necessity Rules	Amendment.	Chapter 1200-13-13 TennCare Medicaid 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 507-6446	July 29, 2005 through Jan 10 , 2006
07-45	July 29, 2005	0620 Finance and Administration Bureau of TennCare	Public Necessity Rules	Amendment.	Chapter 1200-13-14 TennCare Standard 1200-13-14-.08 Providers	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 507-6446	July 29, 2005 through Jan 10 , 2006
07-46	July 29, 2005	0620 Finance and Administration Bureau of TennCare	Public Necessity Rules	Amendment.	Chapter 1200-13-14 TennCare Standard 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits	George Woods Bureau of TennCare 310 Great Circle Road Nashville, TN 37243 (615) 507-6446	July 29, 2005 through Jan 10 , 2006

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TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY - 0720

NOTICE OF BEGINNING OF REVIEW CYCLE

Visit the Tennessee Health Services and Development Agency web site at: <http://www.state.tn.us/hsda/> for the latest Notice of Beginning of Review Cycle.

ANNOUNCEMENTS

**TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT - 0800
WORKERS' COMPENSATION DIVISION**

Andrew Johnson Tower, Second Floor
710 James Robertson Parkway
Nashville, TN 37243-0661

Department of State
Tennessee Tower, William Snodgrass Tower, Eighth Floor
312 8th Avenue North
Nashville, TN 37243

Re: CHAPTER 0800-2-18 MEDICAL FEE SCHEDULE and CHAPTER 0800-2-17 MEDICAL COST CONTAINMENT PROGRAM- Proposed Rules published in the June 2005 Tennessee Administrative Register

To Whom It May Concern:

On behalf of the Tennessee Medical Association, an organization comprised of 6500 members. I am hereby petitioning for a public hearing on the proposed rules establishing a permanent medical fee schedule and medical cost containment program in Tennessee Workers' Compensation program.

Sincerely,

Randall L. Holcomb, M. D.
Chairman TMA Workers' Compensation Task Force

Filed July 13, 2005 (07-13)

EMERGENCY RULES

EMERGENCY RULES NOW IN EFFECT

FOR TEXT OF EMERGENCY RULE SEE T.A.R. CITED

- 1240 - Department of Human Services - Child Support Services Division - Emergency rules pertaining to the calculation of additional expenses in split parenting cases and cases where parenting time is divided on a 50/50 basis, chapter 1240-2-4 Child Support Guidelines, 4 T.A.R., (April 2005) - Filed March 3, 2005; effective through August 15, 2005.
- 1360 - Department of State - Division of Charitable Solicitation - Charitable gaming Division - Emergency rules covering procedures for filing applications, amendments and financial accounting reports for organizations exempt from federal income taxation pursuant to Section 501(c)(3) of the Internal Revenue Code (IRC) who have been authorized by the Tennessee General Assembly to operate charitable gaming events, chapter 1360-3-2 Procedures for Operating Gaming Events, 4 T.A.R., (April 2005) - Filed March 4, 2005; effective through August 16, 2005.

EMERGENCY RULES

THE DEPARTMENT OF AGRICULTURE - 0080 DIVISION OF ANIMAL INDUSTRIES

CHAPTER 0080-2-1 HEALTH REQUIREMENTS FOR ADMISSION AND TRANSPORTATION OF LIVESTOCK AND POULTRY

STATEMENT OF NECESSITY REQUIRING EMERGENCY RULES

Pursuant to Tenn. Code Ann. §4-5-208, the Tennessee Department of Agriculture is promulgating emergency rules in response to the threat of Vesicular Stomatitis introduction into the State of Tennessee.

The Tennessee Department of Agriculture, after research and communication with United States Department of Agriculture and its counterparts in other states, has determined that there is the potential for an immediate threat to animal health and the economic interests of Tennessee necessitating the implementation of the following emergency rules.

Vesicular Stomatitis has been confirmed in horses in portions of central Texas, Arizona, Utah, and New Mexico. Vesicular Stomatitis is a viral disease primarily affecting cattle, horses and swine and occasionally affects sheep and goats. Humans may also become infected if infected animals are handled. Affected livestock have blister-like lesions in the mouth, lips, nostrils, hooves and teats. As the blisters break, raw tissue is painful and may lead to loss of appetite and lameness. The disease causes significant economic loss to livestock producers and is of special concern because clinical signs are similar to foot and mouth disease. Owners and producers in states experiencing an outbreak of Vesicular Stomatitis are subjected to potentially devastating restrictions on sale and movement of their livestock. Additionally, if the disease spreads exports of U. S. livestock in world markets will be severely impacted.

In order to protect Tennessee livestock from the incursion of this disease and to participate with other states in curtailing the spread of the disease into other parts of the country, the following emergency measures are being imposed upon all hoofed animals entering Tennessee from states having confirmed cases of Vesicular Stomatitis.

For copies of the text of the emergency rule, contact: Dr. Ronald B. Wilson, State Veterinarian, Department of Agriculture, P. O. Box 40627, Nashville, Tennessee, 37204, 615-837-5120.

Ronald B. Wilson, D.V.M.
State Veterinarian
State of Tennessee

EMERGENCY RULES

**EMERGENCY RULES
OF THE DEPARTMENT OF AGRICULTURE
DIVISION OF ANIMAL INDUSTRIES**

**CHAPTER 0080-2-1
HEALTH REQUIREMENTS FOR ADMISSION AND
TRANSPORTATION OF LIVESTOCK AND POULTRY**

NEW RULE

TABLE OF CONTENTS

0080-2-1-.17 Restrictions on Shipments From Known Vesicular Stomatitis States or Regions

**0080-2-1-.17 RESTRICTIONS ON SHIPMENTS FROM KNOWN VESICULAR STOMATITIS STATES
OR REGIONS**

- (1) Importation of livestock from a known vesicular stomatitis state or region as designated by the United States Department of Agriculture shall be restricted as follows:
 - (a) No hoofed livestock may enter Tennessee if vesicular stomatitis has been diagnosed within ten (10) miles of the premise of origin since January 1, 2005.
 - (b) All hoofed livestock originating from a location greater than ten (10) miles, but less than one hundred (100 miles), from a premise where vesicular stomatitis has been diagnosed since January 1, 2005, are subject to the following requirements:
 1. Livestock for shipment shall be examined by an accredited veterinarian to determine that they are free from vesicular stomatitis and shall be accompanied by a Certificate of Veterinary Inspection with the following written statement signed by that accredited veterinarian:

“All animals identified on this Certificate of Veterinary Inspection have been examined and found to be free from vesicular stomatitis. During the past 30 days, these animals have neither been exposed to vesicular stomatitis nor located within ten (10) miles of a premise where vesicular stomatitis has been diagnosed.”
 2. Evidence of a negative test for vesicular stomatitis conducted within ten (10) days of shipment is required.
 3. An entry permit number must be obtained from the Tennessee Department of Agriculture by calling 615/837-5120 during normal working hours and must be recorded on the Certificate of Veterinary Inspection for each livestock shipment.
 4. All livestock meeting these requirements will be quarantined upon entry into Tennessee for at least fourteen (14) days, and then inspected by an accredited veterinarian and found to be free of disease prior to release from the quarantine.

Authority: *T.C.A. §§ 44-2-102 and 4-3-203.*

The emergency rules set out herein were properly filed in the Department of State 25th day of July, 2005, and will be effective from the date of filing for a period of 165 days. These emergency rules will remain in effect through the day 6th day of January, 2006. (07-25)

EMERGENCY RULES

THE DEPARTMENT OF COMMERCE AND INSURANCE - 0780 DIVISION OF INSURANCE

CHAPTER 0780-1-88 TENNESSEE HEALTH INSURANCE PORTABILITY, AVAILABILITY AND RENEWABILITY REGULATIONS

STATEMENT OF EMERGENCY REQUIRING EMERGENCY RULES

Pursuant to T.C.A. § 4-5-208, I am promulgating emergency rules with respect to proper standards for health insurance issuers in paying insurance producers that sell contracts of health insurance coverage mandated pursuant to T.C.A. §§ 56-7-2801, *et seq.* The general rulemaking authority is given to me pursuant to T.C.A. § 56-7-2814 which authorizes me to promulgate rules as may be necessary to ensure compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as any rules necessary to carry out the proper administration of the Tennessee Health Insurance Portability, Availability and Renewability Act, T.C.A. §§ 56-7-2801, *et seq.*

I have become aware that some issuers are attempting to discourage the offering of policies to HIPAA-eligible individuals in the individual market or to small groups containing high risk individuals, by withholding commissions from producers for sales to such individuals or small groups. The federal Center for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Association (HCFA), has previously determined and published its conclusion that paying producers less through all forms of agent compensation (commissions, bonuses, or other rewards) for high risk individuals and groups than it pays for those with better risk profiles, constitutes a circumvention of the insurance reform provisions of HIPAA. CMS has declared such actions to be violative of 45 C.F.R. §146.150(a) and 45 C.F.R. §148.120. HCFA Bulletin 98-01 – Insurance Standards Bulletin – Agent Commissions and Application Processing Delays.

The State has recently decided to decrease the number of individuals which are eligible to receive health insurance coverage through TennCare, the state's Medicaid expansion program. The practice of paying producers less by health insurance issuers in this state could lead to individuals being disenrolled from TennCare not having the access to the health insurance coverage they are entitled to under HIPAA. The guaranteed issue provisions of HIPAA, as stated by CMS, generally require that issuers' normal conduits for receiving applications and offering coverage be open to HIPAA-eligible individuals or small employers. Issuers commonly use producers as an important part of their marketing and distribution system, and ordinarily compensate these producers by paying commissions on the coverage they sell. Commission payment is included among the costs used to calculate the premium rate for a given form of coverage. For an issuer to modify the normal operation of its marketing and distribution system so as to avoid its fair share of the high risk individuals and small groups protected by HIPAA, according to CMS, does not accord with the intent of the statute to protect these individuals and groups. Given the recent discovery that health insurance issuers may be engaging in such conduct in this state, and the disenrollment of Tennesseans from the state's Medicaid program, it is the finding of the Commissioner that an immediate danger to the public health, safety and welfare exists, and the nature of this danger is such that the use of any other form of rulemaking authorized by T.C.A. title 4, chapter 5 would not adequately protect the public. It is important to note that CMS published their opinion as to this practice's legality in 1998, and, therefore, these emergency rules only represent a formal promulgation of CMS' interpretation of HIPAA, and do not represent new standards being applied to health insurance issuers in this state.

CMS, in its bulletin, also noted that several states had taken action, under their Unfair Trade Practices Acts or their rating authority, to combat the practice of unfairly reducing or eliminating agent commissions. CMS strongly encouraged the states to continue to use their Unfair Trade Practice Act authority to take actions against these practices.

EMERGENCY RULES

The Department of Commerce and Insurance has also filed a Notice of Rulemaking Hearing to adopt the provisions contained in these emergency rules as permanent rules.

For a copy of the entire text of this notice contact: John F. Morris, Staff Attorney, 500 James Robertson Parkway, Fifth Floor, Davy Crockett Tower, Nashville, Tennessee 37243, Department of Commerce and Insurance, telephone (615) 741-2199.

Paula A. Flowers, Commissioner
Department of Commerce and Insurance

EMERGENCY RULES OF THE DEPARTMENT OF COMMERCE AND INSURANCE DIVISION OF INSURANCE

CHAPTER 0780-1-88 TENNESSEE HEALTH INSURANCE PORTABILITY, AVAILABILITY AND RENEWABILITY REGULATIONS

NEW RULES

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0780-1-88-.01 PURPOSE AND SCOPE.

The purpose of this Chapter is to implement regulations necessary to ensure compliance with the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in scattered sections in 42 U.S.C.), and to implement the minimum standards established by such Act, as well as to implement regulations necessary to carry out the proper administration of the Tennessee Health Insurance Portability, Availability and Renewability Act, T.C.A. §§ 56-7-2801, *et seq.*

Authority: T.C.A. §§ 56-7-2801, *et seq.*, and 56-7-2814, and Pub.L. 104-191, 110 Stat. 1936 (1996).

0780-1-88-.02 DEFINITIONS

- (1) "Compensation" means any consideration given or promised by a health insurance issuer to its producers for the sale of contracts providing health insurance coverage, including but not limited to commissions, bonuses, or other such rewards;
- (2) "Group health plan" means an employee welfare benefit plan, as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise. A program under which creditable coverage is provided shall be treated as a group health plan for the purposes of applying this Chapter;

EMERGENCY RULES

- (3) “Health insurance coverage” means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any policy, certificate, or agreement offered by a health insurance issuer;
- (4) “Health insurance issuer” means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage, including but not limited to, an insurance company, a health maintenance organization and a nonprofit hospital and medical service corporation. “Health insurance issuer” does not mean a group health plan;
- (5) “HIPAA” means the federal Health Insurance Portability and Accountability Act of 1996, Pub.L. 104-191, 110 Stat. 1936 (1996), and the Tennessee Health Insurance Portability, Availability and Renewability Act, T.C.A. §§ 56-7-2801, *et seq.*;
- (6) “Individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan. This includes coverage offered in connection with a group health plan that has fewer than two (2) participants as current employees on the first day of the plan year;
- (7) “Producer” means a person required to be licensed pursuant to T.C.A. title 56, chapter 6, part 1 to sell, solicit or negotiate insurance on behalf of a health insurance issuer in this state.

Authority: T.C.A. §§ 56-7-2802 and 56-7-2814.

0780-1-88-.03 PRODUCER COMPENSATION.

The compensation paid by a health insurance issuer to its producers for a policy of insurance required to be offered by health insurance issuers under HIPAA shall not be less than the compensation paid to its producers for the health insurance issuer’s standard health insurance products.

Authority: T.C.A. §§ 56-7-2814, 56-8-104(6) and 56-8-113, Pub.L. 104-191, 110 Stat. 1936 (1996), 45 C.F.R. §146.150(a), and 45 C.F.R. §148.120.

0780-1-88-.04 PENALTIES.

In addition to any other law or penalty that may apply, violations of 0780-1-88-.03 shall be treated as unfair discrimination and an unfair act or practice under T.C.A. § 56-8-104(6)(B), and shall subject the health insurance issuer to the penalties set forth in T.C.A. § 56-8-109.

Authority: T.C.A. §§ 56-7-2814, 56-8-104(6) and 56-8-113.

0780-1-88-.05 SEVERABILITY.

If any provision of this Chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

Authority: T.C.A. §§ 56-7-2814 and 56-8-113.

EMERGENCY RULES

The emergency rules set out herein were properly filed in the Department of State on the 26th day of July, 2005, and will be effective from the date of filing for a period of 165 days. These emergency rules will remain in effect through the day of the 7th day of January, 2006. (07-32)

ANNOUNCEMENTS

PUBLIC NECESSITY RULES

PUBLIC NECESSITY RULES NOW IN EFFECT

FOR TEXT OF PUBLIC NECESSITY RULE, SEE T.A.R. CITED

- 0180 - Department of Financial Institutions - Compliance Division - Public Necessity rules relating to registration of loan originators, chapter 0180-17 Rules Pertaining to Mortgage Lending, Loan Servicing and Loan Brokering, 4 T.A.R. (April 2005) - Filed March 8, 2005; effective through August 20, 2005. (03-09)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules required to conform the current TennCare Standard rules to reflect changes resulting from the amendment of the TennCare waiver, chapter 1200-13-13 TennCare Medicaid, 6 T.A.R. (June 2005) - Filed May 5, 2005; effective through October 17, 2005. (05-05)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules concerning eligibility, chapter 1200-13-13 TennCare Medicaid, 7 T.A.R. (July 2005) - Filed June 3, 2005; effective through November 15, 2005. (06-06)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules regarding appeals, chapter 1200-13-13 TennCare Medicaid, 7 T.A.R. (July 2005) - Filed June 8, 2005; effective through November 20, 2005. (06-10)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity required to modify the current TennCare rules to reflect changes resulting from the Balanced Budget Act of 2003, chapter 1200-13-14 TennCare Standard, 6 T.A.R. (June 2005) - Filed May 5, 2005; effective through October 17, 2005. (05-06)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules required to conform the current TennCare Standard rules to reflect changes resulting from the amendment of the TennCare waiver, chapter 1200-13-14 TennCare Medicaid, 5 T.A.R. (May 2005) - Filed April 29, 2005; effective through October 11, 2005. (04-18)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules concerning eligibility and enrollment, chapter 1200-13-14 TennCare Standard, 7 T.A.R. (June 2005) - Filed June 3, 2005; effective through November 15, 2005. (06-07)
- 0620 - Department of Finance and Administration - Bureau of TennCare - Public Necessity Rules concerning eligibility and appeals, chapter 1200-13-14 TennCare Standard, 7 T.A.R. (July 2005) - Filed June 8, 2005; effective through November 20, 2005. (06-11)
- 0800 - Department of Labor - Division of Workers' Compensation - Public Necessity Rules regarding Medical Cost Containment Program, chapter 0800-2-17 Medical Cost Containment Program, 7 T.A.R. (July 2005) - Filed June 8, 2005; effective through November 20, 2005. (06-14)
- 0800 - Department of Labor - Division of Workers' Compensation - Public Necessity Rules regarding, chapter 0800-2-18 Medical Fee Schedule, 7 T.A.R. (July 2005) - Filed June 15, 2005; effective through November 27, 2005. (06-15)

PUBLIC NECESSITY RULES

- 0800 - Department of Labor - Division of Workers' Compensation - Public Necessity Rules regarding In-patient fees, chapter 0800-2-19 In-Patient Hospital Fee Schedule, 7 T.A.R. (July 2005) - Filed June 15, 2005; effective through November 27, 2005. (06-16)
- 0800 - Department of Labor - Division of Workers' Compensation - Public Necessity Rules regarding medical impairment rating, chapter 0800-2-20 Medical Impairment Rating Registry Program, 7 T.A.R. (July 2005) - Filed June 15, 2005; effective through November 27, 2005. (06-20)
- 1240 - Department of Human Services - Child Support Division - Public Necessity Rules required in order to maintain compliance with federal requirements, chapter 1240-2-2 Forms for Income Assignments, 6 T.A.R. (June 2005) - Filed May 20, 2005; effective through November 1, 2005. (05-20)
- 1240 - Department of Human Services - Child Support Division - Public Necessity Rules dealing with Child support obligations, 1240-2-2 Forms for Income Assignments, 6 T.A.R. (June 2005) - Filed May 20, 2005; effective through November 1, 2005. (05-21)
- 1540 - TN Higher Education Commission - Public Necessity Rules concerning tuition and fee waiver, chapter 1540-1-4 Public Higher Education Fee Waivers for State Employees, 7 T.A.R. (July 2005) - Filed June 3, 2005; effective through November 15, 2005. (06-02)
- 1540 - TN Higher Education Commission - Public Necessity Rules concerning tuition and fee waiver, chapter 1540-1-5 Public Higher Education Fee Discounts for Children of Licensed Public School Teachers and State Employees, 7 T.A.R. (July 2005) - Filed June 3, 2005; effective through November 15, 2005. (06-04)

EMERGENCY RULES

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620 BUREAU OF TENNCARE

CHAPTER 1200-13-1 GENERAL RULES

STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209 and the Medical Assistance Act, T.C.A. § 71-5-134.

On June 08, 2005, the State of Tennessee received federal approval for certain amendments to the benefits covered under the amendments to the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

This rule is being amended to point out that effective August 1, 2005, coverage of payments to reserve a level I (intermediate) bed during a recipient's temporary absence from a nursing facility care is eliminated.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Medicaid rules to reflect changes resulting from the amendment of the TennCare waiver.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6446.

J. D. Hickey
Deputy Commissioner
Tennessee Department of Finance
and Administration

PUBLIC NECESSITY RULES

**PUBLIC NECESSITY RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE**

**CHAPTER 1200-13-1
GENERAL RULES**

AMENDMENTS

Subparagraphs (r), (u), and (v) of paragraph (1) of rule 1200-13-1-.03 Amount, Duration, and Scope of Assistance is deleted in their entirety and replaced with new subparagraphs which shall read as follows:

- (r) Intermediate Care Facility services for individuals age 65 or older in institutions for tuberculosis will be covered for those who require institutional health services below the level of care rendered in skilled nursing facilities. Effective August 1, 2005, no reimbursement shall be made for days when the patient is not physically present in the facility.
- (u) Intermediate Care facility services for individuals age 65 or older in institutions for mental diseases will be covered for those who require institutional health services below the level of care rendered in skilled nursing facilities. Effective August 1, 2005, no reimbursement shall be made for days when the patient is not physically present in the facility. However, this policy shall not apply to Intermediate Care Facility services for the Mentally Retarded (ICFs/MR).
- (v) Intermediate Care Facility services other than services in an institution for tuberculosis or mental diseases will be covered. Effective August 1, 2005, no reimbursement shall be made for days when the patient is not physically in the facility.

Subparagraph (b) of paragraph (4) of rule 1200-13-1-.06 Provider Reimbursement is amended by adding part 3. which shall read as follows:

- 3. Effective August 1, 2005, no reimbursement shall be made for days when the patient is not physically present in the Level I nursing facility.

Statutory Authority: T.C.A. 4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.

The Public Necessity rules set out herein were properly filed in the Department of State on the 1st day of July, 2005, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 13th day of December, 2005. (07-03)

PUBLIC NECESSITY RULES

**TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620
BUREAU OF TENNCARE**

**CHAPTER 1200-13-13
TENNCARE MEDICAID**

STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209 and the Medical Assistance Act, T.C.A. § 71-5-134.

On June 8, 2005, the State of Tennessee received federal approval for certain amendments to the benefits covered under the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Medicaid rules to reflect changes resulting from the amendment of the TennCare waiver.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6446.

J. D. Hickey
Deputy Commissioner
Tennessee Department of Finance
and Administration

PUBLIC NECESSITY RULES

OF

**TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE**

**CHAPTER 1200-13-13
TENNCARE MEDICAID**

AMENDMENTS

Rule 1200-13-13-.04 Covered Services is amended by adding a new paragraph (8) and renumbering the present paragraph (8) as (9) and subsequent paragraphs renumbered according so as amended the new paragraph (8) shall read as follows:

PUBLIC NECESSITY RULES

(8) Effective August 1, 2005, the covered benefits for TennCare Medicaid will be as follows:

(a) TennCare managed care contractors shall cover, at a minimum, the following services and benefits subject to any applicable limitations described herein effective August 1, 2005. Any and all medically necessary services may require prior authorization or approval by the managed care contractor, except where prohibited by law. In accordance with the *John B. Court Order*, MCCs may not deny medically necessary EPSDT services due to lack of prior authorization. As stated elsewhere in these rules, managed care organizations shall not require prior authorization or approval for services rendered in the event of an emergency need of the enrollee. Such emergency services may be reviewed on the basis of medical necessity or other MCO administrator requirements, but cannot be denied solely because the provider did not obtain prior authorization or approval from the enrollee's managed care organization. Managed care contractors shall not impose any service limitations that are more restrictive than those described herein; however, this provision shall not limit the managed care contractor's ability to establish procedures for the determination of medical necessity. Services for which there is no federal financial participation (FFP) are not covered.

(b) Physical Health and Mental Health Services

SERVICE	BENEFIT
1. Chiropractic Services	Under age 21: Covered as medically necessary. Age 21 and older: Covered when determined cost effective by the MCO.
2. Community Health Services	Under age 21: Covered as medically necessary. Age 21 and older: As medically necessary, except that effective August 1, 2005, Methadone Clinic services for adults age 21 and older are not covered, even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.
3. Convalescent Care	Under age 21: Upon receipt of proof that an enrollee has incurred medically necessary expenses related to convalescent care, TennCare shall pay for up to and including the one-hundredth (100 th) day of confinement during any calendar year for convalescent facility(ies) room, board, and general nursing care, provided: (A) a physician recommends confinement for convalescence; (B) the enrollee is under the continuous care of a physician during the entire period of confinement; and (C) the confinement is required for other than custodial care. Age 21 and older: Effective August 1, 2005, not covered, even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.

PUBLIC NECESSITY RULES

SERVICE	BENEFIT
4. Dental Services	<p>Under age 21: Preventive, diagnostic, and treatment services. Orthodontic services must be prior approved and are limited to individuals under age 21 diagnosed with: (1) a severe handicapping malocclusion or another developmental anomaly or injury resulting in severe malalignment or severe handicapping malocclusion of teeth, documented by at least 28 points on the Salzmann Scale, or any other method that is approved by TennCare, or (2) following repair of an enrollee's cleft palate. Orthodontic treatment will not be authorized for cosmetic purposes. Orthodontic treatment will only be paid for by TennCare as long as the individual remains eligible. If the orthodontic treatment plan is approved prior to the enrollee obtaining 20 ½ years of age, and treatment is initiated prior to the enrollee obtaining 21 years of age, such treatment may continue as long as the enrollee remains eligible.</p> <p>Age 21 and older: Effective August 1, 2005, not covered, even if medically necessary. This includes services which have been prior authorized and/or initiated, but not completed as of August 1, 2005, except for orthodontic treatment as specified above.</p>
5. Durable Medical Equipment	As medically necessary.
6. Emergency Air and Ground Transportation	As medically necessary.
7. EPSDT Services	<p>Under age 21: Covered as medically necessary.</p> <p>Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary in accordance with federal regulations as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under age 21. Except for Dental services, screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care." Dental screens shall be in accordance with the latest periodicity schedule set forth by either the American Academy of Pediatric Dentistry or the American Academy of Pediatrics and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry or the American Academy of Pediatrics.</p> <p>Age 21 and older: Not covered.</p>

PUBLIC NECESSITY RULES

SERVICE	BENEFIT
8. Home Health Care	<p>Under age 21: As medically necessary.</p> <p>Age 21 and older: As medically necessary, all home health care as delivered by a licensed Home Health Agency, as defined by 42 CFR §440.70.</p> <p>A home health visit includes any of the following: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services, and Home Health Aide. Full-time nursing services are not covered for adults 21 years of age and older, except as part of home respiratory therapy services for ventilator-dependent enrollees. (See item 34 in the chart.)</p>
9. Hospice Care	As medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.
10. Inpatient and Outpatient Substance Abuse Benefits	<p>Under age 21: As medically necessary.</p> <p>Age 21 and older: As medically necessary, except that effective August 1, 2005, Methadone Clinic services for adults age 21 and older are not covered even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005. Covered substance abuse treatment services are limited to ten (10) days detox, with a \$30,000 limit in lifetime medically necessary benefits. This limit on covered services does not apply to persons who are Severely and/or Persistently Mentally Ill.</p>
11. Inpatient Hospital Services	As medically necessary. MCO may conduct concurrent and retrospective reviews.
12. Inpatient Rehabilitation Facilities	<p>Under age 21: As medically necessary.</p> <p>Age 21 and older: Inpatient Rehabilitation Facilities services may be covered when determined to be a cost effective alternative by the MCO.</p>
13. Lab and X-ray Services	As medically necessary.
14. Medical Supplies	As medically necessary.

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SERVICE	BENEFIT
15. Non-Emergency Ambulance Transportation	As medically necessary.
16. Non-Emergency Transportation	<p>As necessary to get an enrollee to and from covered services, for enrollees not having access to transportation. MCOs may require advance notice of the need in order to timely arrange transportation.</p> <p>The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services is related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollee's age or lack of parental accompaniment. (Note: Tennessee recognizes the "mature minor exception" to permission for medical treatment.) Any decision to deny transportation of a child due to an enrollee's age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process.</p> <p>The provision of transportation to and from dental services shall remain with the MCO.</p>
17. Occupational Therapy	<p>Under age 21: Covered as medically necessary.</p> <p>Age 21 and older: Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, or stabilize impaired functions.</p>

PUBLIC NECESSITY RULES

SERVICE	BENEFIT
18. Organ Transplant and Donor Organ Procurement	<p>Under age 21: Covered as medically necessary. Experimental or investigational transplants are not covered.</p> <p>Age 21 and older: All medically necessary and non-investigational/experimental organ transplants are covered. These include, but may not be limited to:</p> <p>Bone Marrow/Stem Cell Cornea Heart Heart/Lung Kidney Kidney/Pancreas Liver Lung Pancreas Small bowel/Multi-visceral</p>
19. Outpatient Hospital Services	As medically necessary.
20. Outpatient Mental Health Services (including physician services)	As medically necessary.

PUBLIC NECESSITY RULES

SERVICE	BENEFIT
<p>21. Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long term care facility resident (nursing facility))</p>	<p>As medically necessary, subject to the limitations set out below. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage, or as provided herein at 1200-13-13-.04(7) and 1200-13-13-.10.</p> <p>The following limitations (A) – (D) are effective as of August 1, 2005.</p> <p>(A) Pharmacy services for all children and for individuals receiving TennCare-reimbursed services in a Nursing Facility or Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services waiver have no quantity limits on the number of prescriptions per month.</p> <p>(B) Subject to (A) above, pharmacy services for Categorically Needy adults age 21 and older who are not in the Medically Needy category and included in (A) above or who are eligible in the Medically Needy category as pregnant women are limited to five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) of the five (5) can be brand name drugs. As of August 1, 2005, additional drugs for individuals in (B) shall not be covered even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005 and/or drugs for which the initial prescription but not all applicable refills, or the interim supply, but not the balance thereof, has been received as of August 1, 2005.</p> <p>Prescriptions shall be counted beginning on the first of each calendar month. Each prescription or refill counts as one (1). A prescription or refill can be no more than a 30-day supply. The Bureau of TennCare shall maintain a "Pharmacy Short List" of pharmacy services which shall not count against such pharmacy limit. The Pharmacy Short List may be modified at the discretion of the Bureau of TennCare. The most current version of the Pharmacy Short List will be made available to enrollees via the internet on the TennCare website and upon request by mail through the DHS Family Assistance Centers. Only drugs that are specified on the version of the Pharmacy Short List that is current as of the date of service shall not count against applicable pharmacy limits. TennCare will not cover drugs on the Pharmacy Short List for enrollees whose pharmacy services are not covered.</p>

PUBLIC NECESSITY RULES

SERVICE	BENEFIT
<p>21. Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long term care facility resident (nursing facility)), cont.</p>	<p>Unless specified on the version of the Pharmacy Short List which is current as of the date of pharmacy service, pharmacy services in excess of five (5) prescriptions and/or refills per enrollee per month or two (2) brand name drugs per enrollee per month are non-covered services.</p> <p>(C) Subject to (A) and (B) above, pharmacy services are not covered for Medically Needy adults (age 21 and older) even if medically necessary. This includes services that have been prior authorized and/or initiated but not completed as of August 1, 2005, and/or drugs for which the initial prescription but not all applicable refills, or the interim supply, but not the balance thereof, have been received as of August 1, 2005.</p> <p>(D) Over-the-counter drugs for Medicaid adults (age 21 and older) are not covered even if the enrollee has a prescription for such service, except for prenatal vitamins.</p> <p>TennCare is responsible for the provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible. However, this does not include pharmaceuticals administered in a doctor's office or administered by other vendors under contract with the MCO.</p>

PUBLIC NECESSITY RULES

SERVICE	BENEFIT
22. Physical Therapy	Under age 21: Covered as medically necessary. Age 21 and older: Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, or stabilize impaired functions.
23. Physician Inpatient Services	As medically necessary.
24. Physician Outpatient Services/ Community Health Clinics/ Other Clinic Services	Under age 21: As medically necessary. Age 21 and older: As medically necessary, except that effective August 1, 2005, Methadone Clinic services for adults age 21 and older are not covered, even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.
25. Private Duty Nursing	Under age 21: Covered as medically necessary when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N. who is not an immediate relative. Age 21 and older: Effective August 1, 2005, not covered even if medically necessary. This includes services which have been prior authorized and/or initiated, but not completed as of August 1, 2005.
26. Psychiatric Inpatient Services	As medically necessary.
27. Psychiatric Physician Inpatient Services	As medically necessary.
28. Psychiatric Rehabilitation Services	As medically necessary.

PUBLIC NECESSITY RULES

SERVICE	BENEFIT
29. Reconstructive Breast Surgery	Covered in accordance with Tenn. Code Ann. § 56-7-2507 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
30. Renal Dialysis Services	As medically necessary, for the first ninety (90) days prior to being covered by Medicare.
31. Sitter Services	<p>Under age 21: As medically necessary, a sitter who is not a relative may be used where an enrollee is confined to a hospital as a bed patient and certification is made by a network physician that R.N. or L.P.N. is needed and neither is available.</p> <p>Age 21 and older: As of August 1, 2005, not covered even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.</p>
32. Speech Therapy	<p>Under age 21: Covered as medically necessary.</p> <p>Age 21 and older: Covered as medically necessary, by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment.</p>
33. 24-Hour Psychiatric Residential Treatment	As medically necessary.
34. Ventilator Services	<p>Under 21: As medically necessary.</p> <p>Age 21 and older. Medically necessary home and community-based respiratory therapy services provided outside an institutional setting for ventilator-dependent enrollees, to include nursing services when necessary to prevent institutionalization. Prior approval required.</p>

PUBLIC NECESSITY RULES

SERVICE	BENEFIT
35. Vision Services	<p>Under 21: Preventive, diagnostic, and treatment services (including eyeglasses) are covered as medically necessary</p> <p>Age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered. Routine, periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing, fitting, or changing eyeglasses and/or contact lenses will not be covered.</p>

(c) Pharmacy

TennCare is permitted under the terms and conditions of the demonstration project approved by the federal government to restrict coverage of prescription and non-prescription drugs to a TennCare-approved list of drugs known as a drug formulary. TennCare must make this list of covered drugs available to the public. Through the use of a formulary, the following drugs or classes of drugs, or their medical uses, shall be excluded from coverage or otherwise restricted by TennCare as described in Section 1927 of the Social Security Act [42 U.S.C. §1396r-8]:

1. Agents for weight loss or weight gain.
2. Agents to promote fertility or for the treatment of impotence or infertility or for the reversal of sterilization.
3. Agents for cosmetic purposes or hair growth.
4. Agents for symptomatic relief of coughs and colds.
5. Agents to promote smoking cessation.
6. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
7. Nonprescription drugs.
8. Covered outpatient drugs, which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

TennCare shall not cover drugs considered by the FDA to be Less Than Effective (LTE) and DESI drugs, or drugs considered to be Identical, Related and Similar (IRS) to DESI and LTE drugs or any other pharmacy services for which federal financial participation (FFP) is not available. The exclusion of drugs for which no FFP is available extends to all TennCare enrollees regardless of the enrollee's age. TennCare shall not cover experimental or investigational drugs, which have not received final approval from the FDA.

PUBLIC NECESSITY RULES

Authority: *T.C.A. §§4-5-209, 71-5-105, 71-5-109, 71-5-134, Executive Order No. 23.*

The Public Necessity rules set out herein were properly filed in the Department of State on the 1st day of July, 2005, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 13th day of December, 2005. (07-04)

PUBLIC NECESSITY RULES

**TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620
BUREAU OF TENNCARE**

**CHAPTER 1200-13-13
TENNCARE MEDICAID**

STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209 and the Medical Assistance Act, T.C.A. § 71-5-134.

On June 8, 2005, the State of Tennessee received federal approval for certain amendments to the cost-sharing arrangements covered under the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

This rule is being amended to point out that effective August 1, 2005, TennCare Medicaid adults (age 21 and older) who receive pharmacy services will have nominal copays for certain services.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Medicaid rules to reflect changes resulting from the amendment of the TennCare waiver.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6446.

J. D. Hickey
Deputy Commissioner
Tennessee Department of Finance
and Administration

**PUBLIC NECESSITY RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE
CHAPTER 1200-13-13
AMENDMENT.**

Rule 1200-13-13-.05 Enrollee Cost Sharing is deleted in its entirety and replaced with the following new language to read as follows:

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1200-13-13-.05 ENROLLEE COST SHARING.

- (1) TennCare Medicaid enrollees do not have cost sharing responsibilities for TennCare coverage and covered services, except that effective August 1, 2005, TennCare Medicaid adults (age 21 and older) who receive pharmacy services will have nominal copays for these services. The copays will be \$3.00 (three dollars) for each branded drug and \$0 (zero dollars) for each covered generic drug. Generic drugs which exceed the limit of five (5) prescriptions or refills per enrollee per month are not covered. Family planning drugs and emergency services are exempt from copay. Enrollees may not be denied a service for inability to pay a copay. There is no Out-of-Pocket Maximum on copays.
- (2) The following adult groups are exempt from copay:
 - (a) Individuals receiving hospice services who provide verbal notification of such to the pharmacy provider at the point of service;
 - (b) Individuals who are pregnant who provide verbal notification of such to the pharmacy provider at the point of service; and
 - (c) Individuals who are receiving services in a Nursing Facility, an Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services waiver.

Authority: T.C.A. §§4-5-209, 71-5-105, 71-5-109, 71-5-134 and Executive Order No. 23.

The Public Necessity rules set out herein were properly filed in the Department of State on the 1st day of July, 2005, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 13th day of December, 2005. (07-05)

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**TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620
BUREAU OF TENNCARE**

**CHAPTER 1200-13-13
TENNCARE MEDICAID**

STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209 and the Medical Assistance Act, T.C.A. § 71-5-134.

The State of Tennessee received federal approval for certain amendments to the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

This rule is being amended to point out when a provider can bill an enrollee who has reached his/her established benefit limit.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Medicaid rules to reflect changes resulting from the amendment of the TennCare waiver.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6446.

J. D. Hickey
Deputy Commissioner
Tennessee Department of Finance
and Administration

PUBLIC NECESSITY RULES

OF

**TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE**

CHAPTER 1200-13-13

AMENDMENT.

Paragraph (5) of rule 1200-13-13-.08 Providers is deleted in its entirety and replaced with a new paragraph (5) which shall read as follows:

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- (5) Providers may seek payment from a TennCare enrollee only under the following circumstances:
- (a) If the services are not covered by the TennCare program and the provider informed the enrollee the services were not covered prior to providing the services; or
 - (b) If the services are not covered services because they are in excess of an enrollee's established benefit limit. Before a provider can bill an enrollee for a service that is in excess of the enrollee's established benefit limit, he/she must first submit a claim to the appropriate managed care entity and receive a written denial from the managed care entity. The reason for the denial must be that the service exceeds the enrollee's benefit limit. Only when the provider has a written denial of the service because it is in excess of the enrollee's benefit limit may he/she bill the enrollee for that service.

Authority: T.C.A. §§4-5-209, 71-5-105, 71-5-109, 71-5-134 and Executive Order No. 23.

The Public Necessity rules set out herein were properly filed in the Department of State on the 26th day of July, 2005, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 10th day of January, 2006. (07-43)

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**TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620
BUREAU OF TENNCARE**

**CHAPTER 1200-13-13
TENNCARE MEDICAID**

STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209 and the Medical Assistance Act, T.C.A. § 71-5-134.

The State of Tennessee has received federal approval for certain amendments to the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

These rules are being amended to clarify applicable appeal rights for enrollees who are denied services that are no longer covered by TennCare effective August 1, 2005, including when an enrollee has exceeded the monthly pharmacy benefit limit.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Medicaid rules to reflect changes resulting from the amendment of the TennCare waiver.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6446.

J. D. Hickey
Deputy Commissioner
Tennessee Department of
Finance and Administration

PUBLIC NECESSITY RULES

**PUBLIC NECESSITY RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION**

BUREAU OF TENNCARE

**CHAPTER 1200-13-13
TENNCARE MEDICAID**

AMENDMENTS

Subparagraph (d) of paragraph (1) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding new parts 3. and 4. which shall read as follows:

3. Notwithstanding the requirements of this subsection, effective August 1, 2005, such pharmacy notice will not be provided if the enrollee does not receive the medication of the type and amount prescribed because the pharmacy services are no longer covered by TennCare, including when an enrollee has exceeded the monthly pharmacy benefit limit.
4. Notwithstanding the requirements of this subsection, effective August 1, 2005, pharmacists will verify TennCare coverage for all prescriptions presented by enrollees through the PBM. If the PBM denies coverage because an enrollee has exceeded the applicable pharmacy benefit limit, the PBM will provide appropriate notice to enrollees on behalf of the TennCare Bureau. This notice will only be provided upon the first denial of coverage of a pharmacy service sought by the enrollee that exceeds the monthly five (5) prescription limit or the monthly two (2) prescription limit on branded drugs.

Subparagraph (g) of paragraph (4) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding a new part 6. which shall read as follows:

6. Effective August 1, 2005, notwithstanding the requirements of this subsection, enrollees are not entitled to continuation or reinstatement of services pending an appeal when the service that is the subject of the appeal, even if prescribed, prior authorized and/or initiated or ordered prior to August 1, 2005, was denied because it is no longer covered by TennCare. This includes appeals related to denials of coverage of pharmacy services when the enrollee exceeds the monthly pharmacy benefit limit.

Subparagraph (a) of paragraph (5) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding a new part 5. which shall read as follows:

5. Effective August 1, 2005, notwithstanding the requirements of this subsection, a three-day supply of the prescribed drug will not be provided to enrollees who present a prescription at a pharmacy and are denied coverage because the services are not covered by TennCare, including when enrollees have exceeded the monthly benefit limit.

Paragraph (5) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding new subparagraphs (e) and (f) which shall read as follows:

- (e) The Bureau of TennCare shall establish a tolerance level for early refills of prescriptions. Such established tolerance level may be more stringent for narcotic substances. Notwithstanding the requirements of this subsection, if an enrollee requests a refill of a prescription prior to the tolerance level for early refills established by the Bureau, the pharmacy will deny this

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request as a service which is non-covered until the applicable tolerance period has lapsed, and will not provide a three-day supply of the prescribed drug or written notice in accordance with (1)(d) above.

- (f) Effective October 1, 2003, when providing a supply of a prescribed drug as required under this subsection, TennCare must only provide coverage of a three-day supply of the prescribed drug.

Paragraph (7) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding a new subparagraph (h) which shall read as follows:

- (h) In no circumstance will a directive be issued by the TennCare Solutions Unit or an Administrative Law Judge to provide a service to an enrollee if, when the appeal is resolved, the service is no longer covered by TennCare for the enrollee. A directive also will not be issued by TennCare Solutions Unit if the service cannot reasonably be provided to the enrollee before the date when the service is no longer covered by TennCare for the enrollee and such appeal will proceed to a hearing.

Authority: T.C.A. §§4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.

The Public Necessity rules set out herein were properly filed in the Department of State on the 29th day of July, 2005, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 10th day of January, 2006. (07-44)

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**TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620
BUREAU OF TENNCARE**

**CHAPTER 1200-13-13
TENNCARE MEDICAID**

STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209 and the Medical Assistance Act, T.C.A. § 71-5-134.

The State of Tennessee has received federal approval for certain amendments to the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

These amendments set forth a provision addressing the finality of initial orders issued by the Department of Human Services. They also include certain clarifications to previously filed public necessity rules which define the processes for granting fair hearings based on valid factual disputes before a Hearing Officer or an Administrative Law Judge. Such clarifications further refine the requirements for timely submission of eligibility-based appeals and the continuation of benefits pending resolution of such appeals, including appeals related to disenrollment and changes in eligibility for certain services as a result of certain amendments to the TennCare Demonstration Project. These amendments are intended to supercede the public necessity rules previously filed and effective on June 8, 2005, and continuing through the remainder of the period of effectiveness, will expire on November 20, 2005.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Medicaid rules to reflect changes resulting from the amendment of the TennCare waiver.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6446.

J. D. Hickey
Deputy Commissioner
Department of Finance and Administration

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AMENDMENT

Rule 1200-13-13-.12 Other Appeals By TennCare Applicants and Enrollees is amended by deleting paragraph (1) in its entirety and by substituting instead the following new language so that as amended paragraph (1) shall read as follows:

(1) Appeal Rights of TennCare Medicaid Applicants or Enrollees.

(a) Appeal Time; Continuation of Services.

1. TennCare Medicaid Appeals.

- (i) TennCare Medicaid applicants or enrollees will be given the opportunity to have an administrative hearing before a Hearing Officer or an Administrative Law Judge, as determined by the Department of Human Services, regarding valid factual disputes concerning denial of his/her application, cost sharing disputes, limitation, reduction, suspension or termination of eligibility, failure to act upon a request or application within required timeframes, and disputes regarding disenrollment from TennCare Medicaid. A valid factual dispute is a dispute that, if resolved in favor of the appellant, would prevent the state from taking the action that is the subject of the appeal. The TennCare Bureau designates TDHS to review each request for a hearing to determine if it is based on a valid factual dispute. If TDHS determines that an appeal does not present a valid factual dispute, then TDHS will send the appellant a letter asking him or her to submit additional clarification regarding the appeal within ten (10) days (inclusive of mail time). Unless such clarification is timely received and is determined by TDHS to establish a valid factual dispute, TDHS will dismiss the appeal. TDHS' decisions with respect to determination of whether an appeal raises a valid factual dispute shall not be appealable.
- (ii) Requests for appeals must be made within forty (40) calendar days (inclusive of mail time) of the date of the notice to the applicant/enrollee regarding the intended action or prior to the date of action specified in the notice, whichever is later, notwithstanding anything else in these rules or in the Department of Human Services' administrative procedures rules to the contrary.
- (iii) Enrollees who request a hearing within twenty (20) calendar days (inclusive of mail time) of the date of notice or prior to the date of action specified in the notice, whichever is later, shall retain their eligibility (subject to any changes in covered services generally applicable to enrollees in their TennCare category) pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first. If the appeal results in the

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State's action being sustained, the State reserves its right to recover from the enrollee the cost of services provided to the enrollee during the pendency of the appeal.

- (iv) Enrollees disputing the applicability of changes in coverage to their current TennCare category who request a hearing within twenty (20) calendar days (inclusive of mail time) of the date of the notice or prior to the date of action specified in the notice, whichever is later, shall, notwithstanding subsection 1(a)(1)(iii), continue to receive benefits at the level for the eligibility category alleged by the enrollee to be currently applicable, pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first. If the enrollee does not clearly allege the applicability of a particular eligibility category, benefits will be continued at the level for Non-Institutionalized Medicaid Adults pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first. If TDHS subsequently determines that the enrollee is alleging that a particular eligibility category is currently applicable, benefits will be prospectively continued at the level for such eligibility category pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first.
- (b) To the extent not otherwise modified by this rule, such appeals will be conducted by the Department of Human Services for TennCare Medicaid applicants/enrollees under the Department of Human Services' administrative procedures rules, and in accordance with any other applicable rules, laws or court orders governing those programs, provided that the finality of initial orders shall be governed by the provisions of Tennessee Code Annotated Section 4-5-314(b).
- (c) Appeal Rights for Disenrollment Related to TennCare Medicaid Eligibility Reforms
 1. TennCare Medicaid enrollees, who have not been determined eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in 1200-13-13-.02, will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Termination Notice, notwithstanding anything else in these rules or in the Department of Human Services' administrative procedures rules to the contrary.
 2. To the extent not otherwise modified by this rule, such appeals will be conducted by the Department of Human Services for TennCare Medicaid applicants/enrollees under the Department of Human Services' administrative procedures rules, and in accordance with any other applicable rules, laws or court orders governing those programs, provided that the finality of initial orders shall be governed by the provisions of Tennessee Code Annotated Section 4-5-314(b).
 3. Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day timeframe in which to request a hearing.
 4. Enrollees who request a hearing within twenty (20) calendar days (inclusive of mail time) of the date of notice or prior to the date of termination specified in the Termination Notice, whichever is later, shall retain their eligibility (subject to any changes in covered services generally applicable to enrollees in their TennCare Medicaid category) pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first.

PUBLIC NECESSITY RULES

5. The TennCare Bureau designates TDHS to review each request for hearing to determine if it is based on a valid factual dispute. Enrollees will be given the opportunity to have an administrative hearing before a Hearing Officer or an Administrative Law Judge, as determined by TDHS, regarding valid factual disputes related to termination. If TDHS makes an initial determination that the request for a hearing is not based on a valid factual dispute, the appellant will receive a notice which provides ten (10) days (inclusive of mail time) to provide additional clarification of any factual dispute on which his/her appeal is based. Unless such clarification is timely received and is determined by TDHS to establish a valid factual dispute, a fair hearing will not be granted.
6. TDHS will grant hearings only for those enrollees raising valid factual disputes related to the action of disenrollment. A valid factual dispute is a dispute that, if resolved in favor of the appellant, would prevent the state from taking the adverse action that is the subject of the appeal. Appeals that do not raise a valid factual dispute will not proceed to a hearing. Valid factual disputes include, but are not limited to:
 - (i) Enrollee received the Termination Notice in error (e.g., they are currently enrolled in a TennCare Medicaid category that is not ending);
 - (ii) TDHS failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;
 - (iii) TDHS granted a “good cause” extension of time to reply to the Request for Information Notice but failed to extend the time (this is the only circumstance surrounding good cause which can be appealed) ;
 - (iv) Enrollees requested assistance because of a health, mental health, learning problem or disability but did not receive this assistance; or
 - (v) The TennCare Bureau sent the Request for Information or Termination Notice to the wrong address as defined under state law.
7. If the enrollee does not appeal prior to the date of termination as identified in the Termination Notice, the enrollee will be terminated from TennCare Medicaid.
8. If the enrollee is granted a hearing and the hearing decision sustains the State’s action, the State reserves its right to recover from the enrollee the cost of services provided during the hearing process.

Authority: T.C.A. §§534-5-209, 71-5-105, 71-5-109, Executive Order No. 23

The Public Necessity rules set out herein were properly filed in the Department of State on the 6th day of July, 2005, and will be effective from the date of filing for a period of 137 days. The Public Necessity rules remain in effect through the 20th day of November, 2005. (07-09)

PUBLIC NECESSITY RULES

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620

BUREAU OF TENNCARE

**CHAPTER 1200-13-14
TENNCARE STANDARD**

STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209 and the Medical Assistance Act, T.C.A. § 71-5-134.

On June 8, 2005, the State of Tennessee received federal approval for certain amendments to the benefits covered under the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Standard rules to reflect changes resulting from the amendment of the TennCare waiver.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6446.

J. D. Hickey
Deputy Commissioner
Department of Finance
and Administration

PUBLIC NECESSITY RULES

PUBLIC NECESSITY RULES

OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE

CHAPTER 1200-13-14
TENNCARE STANDARD

AMENDMENT

Rule 1200-13-14-.04 Covered Services is amended by adding a new paragraph (11) and renumbering the present paragraph (11) as (12) and subsequent paragraphs renumbered according so as amended the new paragraph (11) shall read as follows:

(11) Effective August 1, 2005, the covered benefits for TennCare Standard will be as follows:

(a) TennCare managed care contractors shall cover, at a minimum, the following services and benefits subject to any applicable limitations described herein effective August 1, 2005. Any and all medically necessary services may require prior authorization or approval by the managed care contractor, except where prohibited by law. In accordance with the *John B. Court Order*, MCCs may not deny medically necessary services for children under age 21 due to lack of prior authorization. As stated elsewhere in these rules, managed care organizations shall not require prior authorization or approval for services rendered in the event of an emergency need of the enrollee. Such emergency services may be reviewed on the basis of medical necessity or other MCO administrator requirements, but cannot be denied solely because the provider did not obtain prior authorization or approval from the enrollee's managed care organization. Managed care contractors shall not impose any service limitations that are more restrictive than those described herein; however, this provision shall not limit the managed care contractor's ability to establish procedures for the determination of medical necessity. Services for which there is no federal financial participation (FFP) are not covered.

(b) Physical Health and Mental Health Services

SERVICE	BENEFIT
1. Chiropractic Services	Under age 21: Covered as medically necessary. Age 21 and older: Covered when determined cost effective by the MCO.
2. Community Health Services	Under age 21: Covered as medically necessary. Age 21 and older: As medically necessary, except that effective August 1, 2005, Methadone Clinic services for adults age 21 and older are not covered, even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.

PUBLIC NECESSITY RULES

SERVICE	BENEFIT
3. Convalescent Care	<p>Under age 21: Upon receipt of proof that an enrollee has incurred medically necessary expenses related to convalescent care, TennCare shall pay for up to and including the one-hundredth (100th) day of confinement during any calendar year for convalescent facility(ies) room, board, and general nursing care, provided: (A) a physician recommends confinement for convalescence; (B) the enrollee is under the continuous care of a physician during the entire period of confinement; and (C) the confinement is required for other than custodial care.</p> <p>Age 21 and older: Effective August 1, 2005, not covered, even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.</p>
4. Dental Services	<p>Under age 21: Preventive, diagnostic, and treatment services. Orthodontic services must be prior approved and are limited to individuals under age 21 diagnosed with: (1) a severe handicapping malocclusion or another developmental anomaly or injury resulting in severe malalignment or severe handicapping malocclusion of teeth, documented by at least 28 points on the Salzmann Scale, or any other method that is approved by TennCare, or (2) following repair of an enrollee's cleft palate. Orthodontic treatment will not be authorized for cosmetic purposes. Orthodontic treatment will only be paid for by TennCare as long as the individual remains eligible. If the orthodontic treatment plan is approved prior to the enrollee obtaining 20 ½ years of age, and treatment is initiated prior to the enrollee obtaining 21 years of age, such treatment may continue as long as the enrollee remains eligible.</p> <p>Age 21 and older: Effective August 1, 2005, not covered, even if medically necessary. This includes services which have been prior authorized and/or initiated, but not completed as of August 1, 2005, except for orthodontic treatment as specified above.</p>
5. Durable Medical Equipment	As medically necessary.
6. Emergency Air and Ground Transportation	As medically necessary.

PUBLIC NECESSITY RULES

SERVICE	BENEFIT
7. Screening, Inter-periodic Screening, Diagnostic and Follow-up Treatment Services for Children under age 21	<p>Under age 21: Covered as medically necessary.</p> <p>Screening, interperiodic screening, diagnostic and follow-up treatment services as medically necessary. Except for Dental services, screens shall be in accordance with the periodicity schedule set forth in the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care" and all components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care." Dental screens shall be in accordance with the latest periodicity schedule set forth by either the American Academy of Pediatric Dentistry or the American Academy of Pediatrics and all components of the screens must be consistent with the latest recommendations by the American Academy of Pediatric Dentistry or the American Academy of Pediatrics.</p> <p>Age 21 and older: Not covered.</p>
8. Home Health Care	<p>Under age 21: As medically necessary.</p> <p>Age 21 and older: As medically necessary, all home health care as delivered by a licensed Home Health Agency, as defined by 42 CFR §440.70.</p> <p>A home health visit includes any of the following: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services, and Home Health Aide. Full-time nursing services are not covered for adults 21 years of age and older, except as part of home respiratory therapy services for ventilator-dependent enrollees. (See item 34 in this chart.)</p>
9. Hospice Care	As medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.
10. Inpatient and Outpatient Substance Abuse Benefits	<p>Under age 21: As medically necessary.</p> <p>Age 21 and older: As medically necessary, except that effective August 1, 2005, Methadone Clinic services for adults age 21 and older are not covered even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005. Covered substance abuse treatment services are limited to ten (10) days detox, with a \$30,000 limit in lifetime medically necessary benefits. This limit on covered services does not apply to persons who are Severely and/or Persistently Mentally Ill.</p>
11. Inpatient Hospital Services	As medically necessary. MCO may conduct concurrent and retrospective reviews.

PUBLIC NECESSITY RULES

SERVICE	BENEFIT
12. Inpatient Rehabilitation Facilities	<p>Under age 21: As medically necessary.</p> <p>Age 21 and older: Inpatient Rehabilitation Facilities services may be covered when determined to be a cost effective alternative by the MCO.</p>
13. Lab and X-ray Services	As medically necessary.
14. Medical Supplies	As medically necessary.
15. Non-Emergency Ambulance Transportation	As medically necessary.
16. Non-Emergency Transportation	<p>As necessary to get an enrollee to and from covered services, for enrollees not having access to transportation. MCOs may require advance notice of the need in order to timely arrange transportation.</p> <p>The travel to access primary care and dental services must meet the requirements of the waiver terms and conditions. The availability of specialty services is related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee transportation must be provided regardless of whether or not the enrollee has access to transportation. If the enrollee is a child, transportation must be provided for the child and an accompanying adult. However, transportation for a child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollee's age or lack of parental accompaniment. (Note: Tennessee recognizes the "mature minor exception" to permission for medical treatment.) Any decision to deny transportation of a child due to an enrollee's age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process.</p> <p>The provision of transportation to and from dental services shall remain with the MCO.</p>
17. Occupational Therapy	<p>Under age 21: Covered as medically necessary.</p> <p>Age 21 and older: Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, or stabilize impaired functions.</p>

PUBLIC NECESSITY RULES

SERVICE	BENEFIT
18. Organ Transplant and Donor Organ Procurement	<p>Under age 21: Covered as medically necessary. Experimental or investigational transplants are not covered.</p> <p>Age 21 and older: All medically necessary and non-investigational/experimental organ transplants are covered. These include, but may not be limited to:</p> <p>Bone Marrow/Stem Cell Cornea Heart Heart/Lung Kidney Kidney/Pancreas Liver Lung Pancreas Small bowel/Multi-visceral</p>
19. Outpatient Hospital Services	As medically necessary.
20. Outpatient Mental Health Services (including physician services)	As medically necessary.

PUBLIC NECESSITY RULES

SERVICE	BENEFIT
21. Pharmacy Services (obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long term care facility resident (nursing facility))	<p>As medically necessary, subject to the limitations set out below. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage, or as provided herein at 1200-13-14-.04(7) and 1200-13-14-.10.</p> <p>The following limitations (A) – (B) are effective as of August 1, 2005.</p> <p>(A) Pharmacy services for individuals receiving TennCare-reimbursed services in a Nursing Facility or Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services waiver have no quantity limits on the number of prescriptions per month.</p> <p>(B) Pharmacy services for all TennCare Standard adults age 21 and older, other than those included in Group (A) above, are non-covered, effective August 1, 2005, even if medically necessary. This includes drugs which have been prior authorized but not received as of August 1, 2005, and/or drugs for which the initial prescription but not all applicable refills, or the interim supply but not the balance thereof, have been received as of August 1, 2005.</p> <p>TennCare is responsible for the provision and payment of pharmacy benefits to individuals who are enrolled in the TennCare Program in the category of TennCare Medicaid/Medicare dual eligible. However, this does not include pharmaceuticals administered in a doctor's office or administered by other vendors under contract with the MCO.</p>
22. Physical Therapy	<p>Under age 21: Covered as medically necessary.</p> <p>Age 21 and older: Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, or stabilize impaired functions.</p>
23. Physician Inpatient Services	As medically necessary.
24. Physician Outpatient Services/ Community Health Clinics/ Other Clinic Services	<p>Under age 21: As medically necessary.</p> <p>Age 21 and older: As medically necessary, except that effective August 1, 2005, Methadone Clinic services for adults age 21 and older are not covered, even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.</p>

PUBLIC NECESSITY RULES

SERVICE	BENEFIT
25. Private Duty Nursing	<p>Under age 21: Covered as medically necessary when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N. who is not an immediate relative.</p> <p>Age 21 and older: Effective August 1, 2005, not covered even if medically necessary. This includes services which have been prior authorized and/or initiated, but not completed as of August 1, 2005.</p>
26. Psychiatric Inpatient Services	As medically necessary.
27. Psychiatric Physician Inpatient Services	As medically necessary.
28. Psychiatric Rehabilitation Services	As medically necessary.
29. Reconstructive Breast Surgery	Covered in accordance with Tenn. Code Ann. § 56-7-2507 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
30. Renal Dialysis Services	As medically necessary, for the first ninety (90) days prior to being covered by Medicare.
31. Sitter Services	<p>Under age 21: As medically necessary, a sitter who is not a relative may be used where an enrollee is confined to a hospital as a bed patient and certification is made by a network physician that R.N. or L.P.N. is needed and neither is available.</p> <p>Age 21 and older: As of August 1, 2005, not covered even if medically necessary. This includes services that have been prior authorized and/or initiated, but not completed as of August 1, 2005.</p>
32. Speech Therapy	<p>Under age 21: Covered as medically necessary.</p> <p>Age 21 and older: Covered as medically necessary, by a Licensed Speech Therapist to restore speech (as long as there is continued medical progress) after a loss or impairment.</p>

PUBLIC NECESSITY RULES

SERVICE	BENEFIT
33. 24-Hour Psychiatric Residential Treatment	As medically necessary.
34. Ventilator Services	<p>Under 21: As medically necessary.</p> <p>Age 21 and older. Medically necessary home and community-based respiratory therapy services provided outside an institutional setting for ventilator-dependent enrollees, to include nursing services, when necessary to prevent institutionalization. Prior approval required.</p>
35. Vision Services	<p>Under 21: Preventive, diagnostic, and treatment services (including eyeglasses) are covered as medically necessary</p> <p>Age 21 and older: Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of refractive state), will be covered. Routine, periodic assessment, evaluation, or screening of normal eyes and examinations for the purpose of prescribing, fitting, or changing eyeglasses and/or contact lenses will not be covered.</p>

(c) Pharmacy

TennCare is permitted under the terms and conditions of the demonstration project approved by the federal government to restrict coverage of prescription and non-prescription drugs to a TennCare-approved list of drugs known as a drug formulary. TennCare must make this list of covered drugs available to the public. Through the use of a formulary, the following drugs or classes of drugs, or their medical uses, shall be excluded from coverage or otherwise restricted by TennCare as described in Section 1927 of the Social Security Act [42 U.S.C. §1396r-8]:

PUBLIC NECESSITY RULES

1. Agents for weight loss or weight gain.
2. Agents to promote fertility or for the treatment of impotence or infertility or for the reversal of sterilization.
3. Agents for cosmetic purposes or hair growth.
4. Agents for symptomatic relief of coughs and colds.
5. Agents to promote smoking cessation.
6. Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
7. Nonprescription drugs.
8. Covered outpatient drugs, which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

TennCare shall not cover drugs considered by the FDA to be Less Than Effective (LTE) and DESI drugs, or drugs considered to be Identical, Related and Similar (IRS) to DESI and LTE drugs or any other pharmacy services for which federal financial participation (FFP) is not available. The exclusion of drugs for which no FFP is available extends to all TennCare enrollees regardless of the enrollee's age. TennCare shall not cover experimental or investigational drugs, which have not received final approval from the FDA.

Authority: T.C.A. §§ 4-5-209, 71-5-105, 71-5-109, 71-5-134, Executive Order No. 23.

The Public Necessity rules set out herein were properly filed in the Department of State on the 1st day of July, 2005, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 13th day of December, 2005. (07-06)

PUBLIC NECESSITY RULES

**TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620
BUREAU OF TENNCARE**

**CHAPTER 1200-13-14
TENNCARE STANDARD**

STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209 and the Medical Assistance Act, T.C.A. § 71-5-134.

On June 8, 2005, the State of Tennessee received federal approval for certain amendments to the cost-sharing arrangements under the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

This rule is being amended to point out that effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays and pharmacy services.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Medicaid rules to reflect changes resulting from the amendment of the TennCare waiver.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6446.

J. D. Hickey
Deputy Commissioner
Department of Finance
and Administration

PUBLIC NECESSITY RULES

**PUBLIC NECESSITY RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE**

**CHAPTER 1200-13-14
TENNCARE STANDARD**

AMENDMENTS

Subparagraph (a) of paragraph (3) of rule 1200-13-14-.05 Enrollee Cost Sharing is amended by adding the sentence "Effective August 1, 2005, there is no Out of Pocket Maximum for enrollee copays" at the end of the subparagraph so as amended the last paragraph in subparagraph (a) shall read as follows:

Managed care organizations participating in the TennCare program shall be specifically prohibited from waiving, or discouraging TennCare enrollees from paying, the amounts described in this provision. Effective August 1, 2005, there is no Out of Pocket Maximum for enrollee copays.

Subparagraph (a), (b), (d), (e), and (f) of paragraph (7) of rule 1200-13-14-.05 Enrollee Cost Sharing is amended by adding the sentence "Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays" at the end of each subparagraph so as amended the subparagraphs shall read as follows:

- (a) For enrollees in families with incomes equal to or above two hundred (200%) percent of the poverty level, the annual out-of-pocket maximum is two thousand (\$2,000) dollars per individual and four thousand (\$4,000) dollars per family. Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays.
- (b) For enrollees in families with incomes below two hundred (200%) percent of the poverty level, the annual out-of-pocket maximum is one thousand (\$1,000) dollars per individual and two thousand (\$2,000) dollars per family. Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays.
- (d) Effective August 1, 2002, the poverty levels for out-of-pocket maximum will be the poverty levels used by the Tennessee Department of Human Services. Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays.
- (e) Effective January 1, 2003, included in the annual out-of-pocket maximums are monthly out-of-pocket maximums for pharmacy services only. The monthly out-of-pocket maximum for pharmacy services for all TennCare Standard enrollees is one hundred-fifty (\$150.00) dollars per enrollee per month. Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays.
- (f) TennCare Standard enrollees are responsible for requesting a review of his/her out-of-pocket expenditures by TennCare if s/he believes s/he has reached, or is close to reaching, his/her out-of-pocket maximum. Effective August 1, 2005, there is no Out-of-Pocket Maximum for enrollee copays.

Subparagraphs (l), (m), and (n) of paragraph (7) of rule 1200-13-14-.05 Enrollee Cost Sharing is deleted in their entirety and replaced with new subparagraphs (l), (m), and (n) which shall read as follows:

- (l) Pharmacy and Psychiatric Pharmacy Copayments

PUBLIC NECESSITY RULES

1. Effective August 1, 2005, all TennCare Standard enrollees with incomes at or above poverty who receive pharmacy services will have nominal copayments on these services. The copays will be \$3.00 for each branded drug and \$0 for each covered generic drug. Generic drugs which exceed the limit of five (5) prescriptions or refills per enrollee per month are not covered. Family planning drugs and emergency drugs are exempt from copay.
2. The following groups (adults and children) are exempt from copay:
 - (i) Individuals receiving hospice services who provide verbal notification of such to the pharmacy provider at the point of service;
 - (ii) Individuals who are pregnant who provide verbal notification of such to the pharmacy provider at the point of service; and
 - (iii) Individuals who are receiving services in a Nursing Facility, an Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services waiver.
- (m) Effective August 1, 2005, there is no maximum out-of-pocket maximum on pharmacy services.
- (n) The three (3) day supply requirements of the *Grier Revised Consent Decree* do not affect the pharmacy copay requirements. Every prescription for all TennCare Standard enrollees will require a copayment as described herein. In the event the three (3) day supply represents less than a full prescription, the entire copayment will be required.

Authority: T.C.A. §§4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.

The Public Necessity rules set out herein were properly filed in the Department of State on the 1st day of July, 2005, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 13th day of December, 2005. (07-07)

PUBLIC NECESSITY RULES

**TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620
BUREAU OF TENNCARE**

**CHAPTER 1200-13-14
TENNCARE STANDARD**

STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209 and the Medical Assistance Act, T.C.A. § 71-5-134.

The State of Tennessee has received federal approval for certain amendments to the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

This rule is being amended to point out when a provider can bill an enrollee who has reached his/her established benefit limit.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Standard rules to reflect changes resulting from the amendment of the TennCare waiver.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6446.

J. D. Hickey
Deputy Commissioner
Tennessee Department of Finance
and Administration

PUBLIC NECESSITY RULES

**PUBLIC NECESSITY RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION**

BUREAU OF TENNCARE

**CHAPTER 1200-13-14
TENNCARE STANDARD**

AMENDMENT

Paragraph (5) of rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with a new paragraph (5) which shall read as follows:

- (5) Providers may seek payment from a TennCare enrollee only under the following circumstances:
 - (a) If the services are not covered by the TennCare program and the provider informed the enrollee the services were not covered prior to providing the services; or
 - (b) If the services are not covered services because they are in excess of an enrollee's established benefit limit. Before a provider can bill an enrollee for a service that is in excess of the enrollee's established benefit limit, he/she must first submit a claim to the appropriate managed care entity and receive a written denial from the managed care entity. The reason for the denial must be that the service exceeds the enrollee's benefit limit. Only when the provider has a written denial of the service because it is in excess of the enrollee's benefit limit may he/she bill the enrollee for that service.

Authority: T.C.A. §§4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.

The Public Necessity rules set out herein were properly filed in the Department of State on the 29th day of July, 2005, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 10th day of January, 2006. (07-45)

PUBLIC NECESSITY RULES

**TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620
BUREAU OF TENNCARE**

**CHAPTER 1200-13-14
TENNCARE STANDARD**

STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209 and the Medical Assistance Act, T.C.A. § 71-5-134.

The State of Tennessee has received federal approval for certain amendments to the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

These rules are being amended to clarify applicable appeal rights for enrollees who are denied services that are no longer covered by TennCare effective August 1, 2005, including when an enrollee has exceeded the monthly pharmacy benefit limit.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Standard rules to reflect changes resulting from the amendment of the TennCare waiver.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6446.

J. D. Hickey
Deputy Commissioner
Department of Finance and Administration

PUBLIC NECESSITY RULES

**PUBLIC NECESSITY RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION**

BUREAU OF TENNCARE

**CHAPTER 1200-13-14
TENNCARE STANDARD**

AMENDMENTS

Subparagraph (d) of paragraph (1) of rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding new parts 3. and 4. which shall read as follows:

3. Notwithstanding the requirements of this subsection, effective August 1, 2005, such pharmacy notice will not be provided if the enrollee does not receive the medication of the type and amount prescribed because the pharmacy services are no longer covered by TennCare, including when an enrollee has exceeded the monthly pharmacy benefit limit.
4. Notwithstanding the requirements of this subsection, effective August 1, 2005, pharmacists will verify TennCare coverage for all prescriptions presented by enrollees through the PBM. If the PBM denies coverage because an enrollee has exceeded the applicable pharmacy benefit limit, the PBM will provide appropriate notice to enrollees on behalf of the TennCare Bureau. This notice will only be provided upon the first denial of coverage of a pharmacy service sought by the enrollee that exceeds the monthly five (5) prescription limit or the monthly two (2) prescription limit on branded drugs.

Subparagraph (g) of paragraph (4) of rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding a new part 6. which shall read as follows:

6. Effective August 1, 2005, notwithstanding the requirements of this subsection, enrollees are not entitled to continuation or reinstatement of services pending an appeal when the service that is the subject of the appeal, even if prescribed, prior authorized and/or initiated or ordered prior to August 1, 2005, was denied because it is no longer covered by TennCare. This includes appeals related to denials of coverage of pharmacy services when the enrollee exceeds the monthly pharmacy benefit limit.

Subparagraph (a) of paragraph (5) of rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding a new part 5. which shall read as follows:

5. Effective August 1, 2005, notwithstanding the requirements of this subsection, a three-day supply of the prescribed drug will not be provided to enrollees who present a prescription at a pharmacy and are denied coverage because the services are not covered by TennCare, including when enrollees have exceeded the monthly benefit limit.

Paragraph (5) of rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding new subparagraphs (e) and (f) which shall read as follows:

- (e) The Bureau of TennCare shall establish a tolerance level for early refills of prescriptions. Such established tolerance level may be more stringent for narcotic substances. Notwith-

PUBLIC NECESSITY RULES

standing the requirements of this subsection, if an enrollee requests a refill of a prescription prior to the tolerance level for early refills established by the Bureau, the pharmacy will deny this request as a service which is non-covered until the applicable tolerance period has lapsed, and will not provide a three-day supply of the prescribed drug or written notice in accordance with (1)(d) above.

- (f) Effective October 1, 2003, when providing a supply of a prescribed drug as required under this subsection, TennCare must only provide coverage of a three-day supply of the prescribed drug.

Paragraph (7) of rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding a new subparagraph (h) which shall read as follows:

- (h) In no circumstance will a directive be issued by the TennCare Solutions Unit or an Administrative Law Judge to provide a service to an enrollee if, when the appeal is resolved, the service is no longer covered by TennCare for the enrollee. A directive also will not be issued by TennCare Solutions Unit if the service cannot reasonably be provided to the enrollee before the date when the service is no longer covered by TennCare for the enrollee and such appeal will proceed to a hearing.

Authority: T.C.A. §§4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.

The Public Necessity rules set out herein were properly filed in the Department of State on the 29th day of July, 2005, and will be effective from the date of filing for a period of 165 days. The Public Necessity rules remain in effect through the 10th day of January, 2006. (07-46)

PUBLIC NECESSITY RULES

**TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620
BUREAU OF TENNCARE**

**CHAPTER 1200-13-14
TENNCARE STANDARD**

STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES

I am herewith submitting amendments to the rules of the Tennessee Department of Finance and Administration, Bureau of TennCare, for promulgation pursuant to the public necessity provisions of the Uniform Administrative Procedures Act, T.C.A. § 4-5-209 and the Medical Assistance Act, T.C.A. § 71-5-134.

The State of Tennessee has received federal approval for certain amendments to the TennCare Demonstration Project (No. 11-W-0015 1/4). Approval of the project modification is granted under the authority of Section 1115 (a) of the Social Security Act. The amendments are approved through the period ending June 30, 2007. The TennCare program is a managed care program for both the Medicaid population and the expansion population.

These amendments set forth a provision addressing the finality of initial orders issued by the Department of Human Services. They also include certain clarifications to previously filed public necessity rules which define the processes for granting fair hearings based on valid factual disputes before a Hearing Officer or an Administrative Law Judge. Such clarifications further refine the requirements for timely submission of eligibility-based appeals and the continuation of benefits pending resolution of such appeals, including appeals related to disenrollment and changes in eligibility for certain services as a result of certain amendments to the TennCare Demonstration Project. These amendments are intended to supercede the public necessity rules previously filed and effective on June 8, 2005, and continuing through the remainder of the period of effectiveness, will expire on November 20, 2005.

Tennessee Code Annotated, Section 71-5-134, states that in order to comply with or to implement the provisions of any federal waiver or state plan amendment obtained pursuant to the Medical Assistance Act as amended by Acts 1993, the Commissioner of Finance and Administration is authorized to promulgate public necessity rules pursuant to Tennessee Code Annotated, Section 4-5-209.

I have made a finding that these amendments are required to conform the current TennCare Standard rules to reflect changes resulting from the amendment of the TennCare waiver.

For a copy of this public necessity rule, contact George Woods at the Bureau of TennCare by mail at 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6446.

J. D. Hickey
Deputy Commissioner
Department of Finance
and Administration

PUBLIC NECESSITY RULES

**PUBLIC NECESSITY RULES
OF
TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION
BUREAU OF TENNCARE**

**CHAPTER 1200-13-14
TENNCARE STANDARD**

AMENDMENT

Rule 1200-13-14-.12 Other Appeals By TennCare Applicants and Enrollees is amended by deleting subparagraph (1)(a) in its entirety and substituting instead the following new language, and is further amended by adding the following new subparagraphs (1)(b) and 1(c) and renumbering the remaining subparagraphs accordingly, so that the new subparagraphs (1)(a), (1)(b) and (1)(c) shall read as follows:

(1) Appeal Rights of TennCare Standard Applicants or Enrollees.

(a) Appeal Time; Continuation of Services.

1. TennCare Standard Appeals.

- (i) TennCare Standard applicants or enrollees will be given the opportunity to have an administrative hearing before a Hearing Officer or an Administrative Law Judge, as determined by the Department of Human Services, regarding valid factual disputes concerning denial of his/her application, cost sharing disputes, limitation, reduction, suspension or termination of eligibility, failure to act upon a request or application within required timeframes, and disputes regarding disenrollment from TennCare Standard. A valid factual dispute is a dispute that, if resolved in favor of the appellant, would prevent the state from taking the action that is the subject of the appeal. The TennCare Bureau designates TDHS to review each request for a hearing to determine if it is based on a valid factual dispute. If TDHS determines that an appeal does not present a valid factual dispute, then TDHS will send the appellant a letter asking him or her to submit additional clarification regarding the appeal within ten (10) days (inclusive of mail time). Unless such clarification is timely received and is determined by TDHS to establish a valid factual dispute, TDHS will dismiss the appeal. TDHS' decisions with respect to determination of whether an appeal raises a valid factual dispute shall not be appealable.
- (ii) Requests for appeals must be made within forty (40) calendar days (inclusive of mail time) of the date of the notice to the applicant/enrollee regarding the intended action or prior to the date of action specified in the notice, whichever is later, notwithstanding anything else in these rules or in the Department of Human Services' administrative procedures rules to the contrary.
- (iii) Enrollees who request a hearing within twenty (20) calendar days (inclusive of mail time) of the date of notice or prior to the date of action specified in the notice, whichever is later, shall retain their eligibility (subject to any changes in covered services generally applicable to enrollees in their TennCare category) pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first. If the appeal results in the State's action being sustained, the State reserves its right to recover from the enrollee the cost of services provided to the enrollee during the pendency of the appeal.

PUBLIC NECESSITY RULES

- (iv) Enrollees disputing the applicability of changes in coverage to their current TennCare category who request a hearing within twenty (20) calendar days (inclusive of mail time) of the date of the notice or prior to the date of action specified in the notice, whichever is later, shall, notwithstanding subsection 1(a)(1)(iii), continue to receive benefits at the level for the eligibility category alleged by the enrollee to be currently applicable, pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first. If the enrollee does not clearly allege the applicability of a particular eligibility category, benefits will be continued at the level for Non-Institutionalized Medicaid Adults pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first. If TDHS subsequently determines that the enrollee is alleging that a particular eligibility category is currently applicable, benefits will be prospectively continued at the level for such eligibility category pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first.
- (b) To the extent not otherwise modified by this rule, such appeals will be conducted by the Department of Human Services for TennCare Standard applicants/enrollees under the Department of Human Services' administrative procedures rules, and in accordance with any other applicable rules, laws or court orders governing those programs, provided that the finality of initial orders shall be governed by the provisions of Tennessee Code Annotated Section 4-5-314(b).
- (c) Appeal Rights for Disenrollment Related to TennCare Standard Eligibility Reforms
 - 1. TennCare Standard enrollees, who have not been determined eligible for open Medicaid categories pursuant to the Ex Parte Review or Request for Information processes described in 1200-13-14-.02, will have the right to request a hearing for 40 days (inclusive of mail time) from the date of the Termination Notice, notwithstanding anything else in these rules or in the Department of Human Services' administrative procedures rules to the contrary.
 - 2. To the extent not otherwise modified by this rule, such appeals will be conducted by the Department of Human Services for TennCare Standard applicants/enrollees under the Department of Human Services' administrative procedures rules, and in accordance with any other applicable rules, laws or court orders governing those programs, provided that the finality of initial orders shall be governed by the provisions of Tennessee Code Annotated Section 4-5-314(b).
 - 3. Enrollees will not have the opportunity to request an extension for good cause of the forty (40) day timeframe in which to request a hearing.
 - 4. Enrollees who request a hearing within twenty (20) calendar days (inclusive of mail time) of the date of notice or prior to the date of termination specified in the Termination Notice, whichever is later, shall retain their eligibility (subject to any changes in covered services generally applicable to enrollees in their TennCare category) pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first.

PUBLIC NECESSITY RULES

5. The TennCare Bureau designates TDHS to review each request for hearing to determine if it is based on a valid factual dispute. Enrollees will be given the opportunity to have an administrative hearing before a Hearing Officer or an Administrative Law Judge, as determined by TDHS, regarding valid factual disputes related to termination. If TDHS makes an initial determination that the request for a hearing is not based on a valid factual dispute, the appellant will receive a notice which provides 10 days (inclusive of mail time) to provide additional clarification of any factual dispute on which his/her appeal is based. Unless such clarification is timely received and is determined by TDHS to establish a valid factual dispute, a fair hearing will not be granted.
6. TDHS will grant hearings only for those enrollees raising valid factual disputes related to the action of disenrollment. A valid factual dispute is a dispute that, if resolved in favor of the appellant, would prevent the state from taking the adverse action that is the subject of the appeal. Appeals that do not raise a valid factual dispute will not proceed to a hearing. Valid factual disputes include, but are not limited to:
 - (i) Enrollee received the Termination Notice in error (e.g., they are currently enrolled in a TennCare Medicaid or TennCare Standard category that is not ending);
 - (ii) TDHS failed to timely process information submitted by the enrollee during the requisite time period following the Request for Information or Verification Request;
 - (iii) TDHS granted a "good cause" extension of time to reply to the Request for Information Notice but failed to extend the time (this is the only circumstance surrounding good cause which can be appealed) ;
 - (iv) Enrollees requested assistance because of a health, mental health, learning problem or disability but did not receive this assistance; or
 - (v) The TennCare Bureau sent the Request for Information or Termination Notice to the wrong address as defined under state law.
7. If the enrollee does not appeal prior to the date of termination as identified in the Termination Notice, the enrollee will be terminated from TennCare.
8. If the enrollee is granted a hearing and the hearing decision sustains the State's action, the State reserves its right to recover from the enrollee the cost of services provided during the hearing process.

Authority: T.C.A. §§4-5-209, 71-5-105, 71-5-109, Executive Order No. 23.

The Public Necessity rules set out herein were properly filed in the Department of State on the 6th day of July, 2005, and will be effective from the date of filing for a period of 137 days. The Public Necessity rules remain in effect through the 20th day of November, 2005. (07-08)

PUBLIC NECESSITY RULES

**THE TENNESSEE DEPARTMENT OF HUMAN SERVICES - 1240
FAMILY ASSISTANCE DIVISION**

**CHAPTER 1240-1-50
FINANCIAL ELIGIBILITY REQUIREMENTS
FAMILIES FIRST PROGRAM**

STANDARD OF NEED/INCOME

STATEMENT OF NECESSITY REQUIRING PUBLIC NECESSITY RULES

Tennessee Code Annotated, Section 71-3-155(e) requires that the standard of need for recipients of temporary assistance in the Families First program for the fiscal year be set by rule of the Tennessee Department of Human Services on July 1 of each year. TCA Section 71-3-155(f) further requires that the maximum grants be set, as a percentage of the standard of need, in the annual Appropriations Act or in rule of the Department. Additionally, because the amount of funding available for grants and the new standard of need is not known until the passage of the annual Appropriations Act [Section 10, Item 21, Senate Bill 2315/House Bill 2331 (2005)] which did not occur until May 28th of 2005, and because the law requires that the standard of need and grant amounts be set by rule to be effective on July 1 of the fiscal year, it is not possible to establish rules by regular rulemaking procedures.

For a complete copy of these public necessity rules, contact: Phyllis Simpson, Assistant General Counsel, Tennessee Department of Human Services, Citizens Plaza Building, 400 Deaderick Street, 15th Floor, Nashville, TN 37248-0006, telephone number (615) 313-4731.

Virginia T. Lodge
Commissioner
Tennessee Department of Human Services

**PUBLIC NECESSITY RULES
OF
THE TENNESSEE DEPARTMENT OF HUMAN SERVICES
FAMILY ASSISTANCE DIVISION**

**CHAPTER 1240-1-50
FINANCIAL ELIGIBILITY REQUIREMENTS
FAMILIES FIRST PROGRAM**

AMENDMENTS

Rule 1240-1-50-.20 Standard Of Need/Income, is amended by deleting the Rule in its entirety and by substituting instead the following language so that, as amended, the rule shall read:

1240-1-50-.20 Standard Of Need/Income. The following table shows the maximum income level, consolidated standard of need, and the possible standard payment amounts and differential grant payment amounts (maximum payment per assistance group size) to be used in the Families First program to determine eligibility and amount of payment.

- (1) Families First Cash Assistance Standards

PUBLIC NECESSITY RULES

- (a) Consolidated Need Standard (CNS). The Department has developed a consolidated standard of need based on size of the assistance group (AG), which indicates the amount of income the assistance group would need to meet subsistence living costs according to allowances set by the state for items including food, clothing, shelter and utilities, transportation, medical care, personal incidentals, and school supplies. The CNS is used as the basis for determining the gross income standard (GIS), the standard payment amount (SPA), and the Differential Grant Payment Amount (DGPA).
- (b) Gross Income Standard (GIS). This standard is set at One Hundred Eighty-Five Percent (185%) of the consolidated need standard. If the gross countable income of an assistance group exceeds this standard, the Assistance Group (AG) is not eligible for Families First.
- (c) Standard Payment Amount (SPA). Tennessee does not meet One Hundred Percent (100%) of need as defined by the consolidated need standard. Rather, a maximum payment by family size, dependent on available State and Federal funds is paid, except in the instances specified in 1240-1-50-.20(e).
- (d) Differential Grant Payment Amount (DGPA). A Families First Assistance Group which meets any one of the criteria for exemption from Time Limited Assistance as specified in 1240-1-51-.01(4)(a) through (d), will be eligible for a grant based on the Differential Grant Payment Amount (DGPA), which is a maximum payment by family size, dependent on funds available, except in the instances specified in subparagraph (e) below.
- (e) Family Benefit Cap
 - 1. No additional benefits will be issued due to the birth of a child when the birth occurs more than ten (10) calendar months after the later of:
 - (i) the date of application for Families First, or
 - (ii) the date of implementation of the Families First program (September 1, 1996), as provided by T.C.A. § 71-3-151, unless:
 - (I) the child was conceived as the result of verified rape or incest;
 - (II) the child is the firstborn (including all children in the case of a multiple birth) of a minor included in the Families First grant who becomes a first-time minor parent;
 - (III) the child does not reside with his/her parent;
 - (IV) the child was conceived in a month the AG was not receiving Families First; or
 - (V) the child was already born prior to the later of the date of application for Families First or the date of implementation of Families First, and the child has entered or returned to the home.
 - 2. The additional child will be included in the need standard for the purpose of determining Families First eligibility. The income of the child, including child support, will be applied against the need standard in determining the

PUBLIC NECESSITY RULES

Families First payment amount for the family. The child will be considered a Families First recipient for all other purposes, including Medicaid/TennCare coverage.

3. The family benefit cap will not apply to a subsequent period of eligibility for families who reapply for Families First subsequent to receipt of cash assistance for an eighteen (18)-month eligibility period during which the child was born, as long as the reason for prior case closure was other than a failure to comply with work or child support enforcement requirements or other Personal Responsibility Plan provisions, and the parent/caretaker had cooperated with the Department as defined in departmental policies for the Families First program.
 - (i) Departmental policies and rules with which the parent/caretaker must cooperate include, but are not limited to:
 - (I) Child support cooperation requirements, such as identifying the absent parent, meeting with child support enforcement staff, submitting a child for blood testing, and testifying in court if necessary;
 - (II) Carrying out and fulfilling Personal Responsibility Plan provisions and requirements; or
 - (III) Carrying out and fulfilling Work Plan provisions and requirements.
- (f) An assistance payment is determined as follows:
 1. If the assistance group's net income (after allowable exclusions and deductions) equals or exceeds their consolidated need, the assistance group is not eligible.
 2. If the assistance group's net income is less than their consolidated need, the monthly grant amount is the smaller of a maximum payment amount by family size (SPA or DGPA, as appropriate) or the deficit if it is ten dollars (\$10) or more. If the deficit is one dollar (\$1) - nine dollars (\$9), the AG is eligible for Medicaid (TennCare) only, and is deemed to be a Families First recipient group.

In the case of an AG receiving Families First because one or both parents are unemployed, if the Principal Wage Earner (PWE) receives Unemployment Compensation (UC) the UC benefit is deducted from the grant amount determined after deducting all other countable income from the CNS, to determine the actual amount of Families First payment for the AG.
 3. The minimum monthly grant which can be paid is ten dollars (\$10).
- (g) Families First Need/Payment Standards
 1. Tables

PUBLIC NECESSITY RULES

TABLE I

Number of Persons in Assistance Group	1	2	3	4	5	6	7	8	9	10
Gross Income Standard	1141	1469	1743	1972	2163	2322	2455	2570	2671	2760
Consolidated Need Standard	617	794	942	1066	1169	1255	1327	1389	1444	1492
Maximum Payment (SPA)	95	142	185	226	264	305	345	386	425	467

Minimum Families First Payment is \$10 per month for any Assistance Group

Number of Persons in Assistance Group	11	12	13	14	15	16	17	18	19	20
Gross Income Standard	2842	2917	2988	3056	3119	3176	3228	3269	3299	3310
Consolidated Need Standard	1536	1577	1615	1652	1686	1717	1745	1767	1783	1789
Maximum Payment (SPA)	508	549	589	630	670	711	750	790	831	871

Minimum Families First Payment is \$10 per month for any Assistance Group

TABLE II

Number of Persons in Assistance Group	1	2	3	4	5	6	7	8	9	10
Gross Income Standard	1141	1469	1743	1972	2163	2322	2455	2570	2671	2760
Consolidated Need Standard	617	794	942	1066	1169	1255	1327	1389	1444	1492

PUBLIC NECESSITY RULES

Maximum Payment (DGPA)	140	192	232	242	291	305	345	386	425	467
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Minimum Families First Payment is \$10 per month for any Assistance Group

Number of Persons in Assistance Group	11	12	13	14	15	16	17	18	19	20
Gross Income Standard	2842	2917	2988	3056	3119	3176	3228	3269	3299	3310
Consolidated Need Standard	1536	1577	1615	1652	1686	1717	1745	1767	1783	1789
Maximum Payment (DGPA)	508	549	589	630	670	711	750	790	831	871

Minimum Families First Payment is \$10 per month for any Assistance Group

2. The Families First standard payment amount (maximum payment) for an assistance group of three (3) persons represents 19.6% of the consolidated need for an assistance group of that size. The Families First maximum differential grant payment amount for an assistance group of three (3) persons represents 24.6% of the consolidated need for an assistance group of that size. The payments for groups composed of different numbers of recipients represent an upward or downward adjustment of the percentage in the preceding sentences which is necessary to maintain the payment at a level not more or less than that paid in fiscal year 2004-2005.
3. Standard for Families First Transitional Services
 - (i) Families First assistance groups and other low-income families may receive transitional services after the Families First case closes.
 - (ii) For purposes of this Part, "transitional services" is defined as services to assist the customer in attaining long-term self-sufficiency.
 - (iii) Transitional services will be provided subject to the continued availability of state and/or federal funding.
 - (iv) In order to receive these services, the assistance group's gross monthly income must meet a standard of need.

PUBLIC NECESSITY RULES

- (v) The standard of need for transitional services under this Part is defined as Two Hundred Percent (200%) of the Federal poverty level for the assistance group family size. The standard of need for this Part does not apply to Transitional Child Care or Transitional Medicaid.

Authority: *T.C.A. §§ 4-5-209, 71-1-105, 71-3-151—71-3-165, 71-3-154(i), and 71-3-155(e)-(g); Senate Bill 2315/House Bill 2331 (2005); 42 U.S.C. §§ 601 et seq.; 42 U.S.C. § 1315; and 45 C.F.R. § 233.20.*

The public necessity rules set out herein were properly filed in the Department of State on the 1st day of July, 2005 and will be effective from the date of filing for a period of 165 days. These public necessity rules will remain in effect through the 13th day of December, 2005. (07-01)

RULEMAKING HEARINGS

THE DEPARTMENT OF COMMERCE AND INSURANCE - 0780 INSURANCE DIVISION

There will be a hearing before the Insurance Division of the Department of Commerce and Insurance ("Division") to consider the promulgation of rules. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in Conference Room A of the Davy Crockett Tower located at 500 James Robertson Parkway, Nashville, Tennessee 37243 at 10:00 a.m. CST on the 15th day of September, 2005.

Any individuals with disabilities who wish to participate in these proceedings should contact the Division to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date, to allow time for the Division to determine how it may reasonably provide such aid or service. Initial contact may be made with the Division's ADA Coordinator at Davy Crockett Tower, 500 James Robertson Parkway, Nashville, Tennessee 37243 and (615) 741-6500.

For a copy of this notice of rulemaking hearing contact: John F. Morris, Staff Attorney, Office of Legal Counsel, Davy Crockett Tower, Fifth Floor, Nashville, Tennessee 37243, Department of Commerce and Insurance, and (615) 741-2199.

SUBSTANCE OF PROPOSED RULES

CHAPTER 0780-1-58 MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS AMENDMENTS

Chapter 0780-1-58 Medicare Supplement Insurance Minimum Standards is amended by deleting the chapter in its entirety and substituting the following language so that, as amended, the chapter shall read:

CHAPTER 0780-1-58 MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

RULEMAKING HEARINGS

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RULEMAKING HEARINGS

0780-1-58-.01 PURPOSE.

The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

Authority: *T.C.A. §§ 56-2-301, 56-7-1425 through 1430, and 56-7-1451 through 56-7-1459.*

0780-1-58-.02 AUTHORITY.

This regulation is issued pursuant to the authority vested in the Commissioner under T.C.A. § 56-2-301, the Medicare Supplemental Insurance Protection Act, Tenn. Code Ann. §§ 56-7-1425 through 1430, and Tenn. Code Ann. §§ 56-7-1451 through 1459.

Authority: *T.C.A. §§ 56-2-301, 56-7-1425 through 1430, and 56-7-1451 through 56-7-1459.*

0780-1-58-.03 APPLICABILITY AND SCOPE.

- (1) Except as otherwise specifically provided in Rules .07, .12, .13, .16, and .21, this Chapter shall apply to:
 - (a) All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this Chapter; and
 - (b) All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.
- (2) This Chapter shall not apply to a policy or contract of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

Authority: *T.C.A. §§ 56-2-301, 56-7-1425 through 1430, and 56-7-1451 through 56-7-1459.*

0780-1-58-.04 DEFINITIONS.

For purposes of this Chapter:

- (1) "Applicant" means:
 - (a) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and
 - (b) In the case of a group Medicare supplement policy, the proposed certificate holder.

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- (2) "Bankruptcy" means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.
- (3) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.
- (4) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.
- (5) "CMS" means the Centers for Medicare & Medicaid Services.
- (6) "Commissioner" means the Commissioner of the Tennessee Department of Commerce and Insurance.
- (7) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of coverage the individual had no breaks in coverage greater than sixty-three (63) days.
- (8) (a) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:
 - 1. A group health plan;
 - 2. Health insurance coverage;
 - 3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
 - 4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;
 - 5. Chapter 55 of Title 10 United States Code (CHAMPUS);
 - 6. A medical care program of the Indian Health Service or of a tribal organization;
 - 7. A State health benefits risk pool;
 - 8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
 - 9. A public health plan as defined in federal regulation; and
 - 10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).
- (a) "Creditable coverage" shall not include one or more, or any combination of the following:
 - 1. Coverage only for accident or disability income insurance, or any combination thereof;
 - 2. Coverage issued as a supplement to liability insurance;

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3. Liability insurance, including general liability insurance and automobile liability insurance;
 4. Workers' compensation or similar insurance;
 5. Automobile medical payment insurance;
 6. Credit-only insurance;
 7. Coverage for on-site medical clinics; and
 8. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (b) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
1. Limited scope dental or vision benefits;
 2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
 3. Such other similar, limited benefits as are specified in federal regulations.
- (c) "Creditable coverage" shall not include the following benefits if offered as independent, non-coordinated benefits:
1. Coverage only for a specified disease or illness; and
 2. Hospital indemnity or other fixed indemnity insurance.
- (d) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:
1. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
 2. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and
 3. Similar supplemental coverage provided to coverage under a group health plan.
- (9) "Department" means the Tennessee Department of Commerce and Insurance.
- (10) "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).
- (11) "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

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- (12) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.
- (13) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.
- (14) "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in Section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33, and includes:
 - (a) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;
 - (b) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and
 - (c) Medicare Advantage private fee-for-service plans.
- (15) "Medicare supplement policy" means a group or individual policy of [accident and sickness] insurance or a subscriber contract [of hospital and medical service associations or health maintenance organizations], other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Sections 1395, *et seq.*) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.
- (16) "NAIC" means the National Association of Insurance Commissioners.
- (17) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.
- (18) "Secretary" means the Secretary of the United States Department of Health and Human Services.

Authority: T.C.A. §§ 56-2-301, 56-7-1425 through 1430, and 56-7-1451 through 56-7-1459.

0780-1-58-.05 POLICY DEFINITIONS AND TERMS.

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

- (1) "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

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- (a) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."
- (b) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.
- (2) "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.
- (3) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.
- (4) "Health care expenses" means, for purposes of Rule 0780-1-58-.14, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.
- (5) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.
- (6) "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.
- (7) "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.
- (8) "Physician" shall not be defined more restrictively than as defined in the Medicare program.
- (9) "Sickness" shall not be defined to be more restrictive than the following:
 - (a) "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force."
 - (b) The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

Authority: T.C.A. § 56-7-1453(c).

0780-1-58-.06 POLICY PROVISIONS.

- (1) Except for permitted preexisting condition clauses as described in Rules 0780-1-58-.07(a)1. and 0780-1-58-.08(a)1., no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more than those of Medicare.

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- (2) No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.
- (3) No Medicare supplement policy or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.
- (4)
 - (a) Subject to Rules 0780-1-58-.07(1)(d), (e) and (g), and 0780-1-58-.08(1)(d) and (e), a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.
 - (b) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.
 - (c) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:
 - 1. The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan; and
 - 2. Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

Authority: *T.C.A. § 56-7-1453(c) and (e).*

0780-1-58-.07 MINIMUM BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED FOR DELIVERY PRIOR TO JULY 1, 1992.

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

- (1) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.
 - (a) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.
 - (b) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

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- (c) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be modified to correspond with such changes.
- (d) A “noncancellable,” “guaranteed renewable,” or “noncancellable and guaranteed renewable” Medicare supplement policy shall not:
 - 1. Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or
 - 2. Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.
- (e)
 - 1. Except as authorized by the Commissioner, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.
 - 2. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Subparagraph (a)5.(iv) of this Paragraph, the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:
 - (i) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and
 - (ii) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Rule 0780-1-58-.08(b).
 - 3. If membership in a group is terminated, the issuer shall:
 - (i) Offer the certificate holder the conversion opportunities described in Subparagraph (a)5.(ii) of this Paragraph; or
 - (ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.
 - 4. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.
- (c) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force but the extension of benefits beyond the period during which the policy was in force may be

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predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

- (d) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this Rule.

(3) Minimum Benefit Standards.

- (a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first (61st) day through the ninetieth (90th) day in any Medicare benefit period;
- (b) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;
- (c) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;
- (d) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;
- (e) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;
- (f) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [\$100];
- (g) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

Authority: T.C.A. § 56-2-301.

0780-1-58-.08 BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED OR DELIVERED ON OR AFTER JULY 1, 1992.

The standards required by this Rule are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 1, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with the benefit standards set forth in this Rule.

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- (1) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Chapter:
- (a) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.
 - (b) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
 - (c) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.
 - (d) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
 - (e) Each Medicare supplement policy shall be guaranteed renewable.
 - 1. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.
 - 2. The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.
 - 3. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Subparagraph (v) below, the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):
 - (i) Provides for continuation of the benefits contained in the group policy; or
 - (ii) Provides for benefits that otherwise meet the requirements of this subsection.
 - 4. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:
 - (i) Offer the certificateholder the conversion opportunity described in Subpart (3) of this Subparagraph (e); or
 - (ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.
 - 5. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the

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replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

6. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this Rule.
- (f) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.
- (g)
1. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.
 2. If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.
 3. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.
 4. Reinstitution of coverages as described in Subparagraphs (g)1. and (g)2. of this Paragraph:
 - (i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

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- (ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and
- (iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(3) Standards for Basic (Core) Benefits Common to Benefit Plans A – J.

Every issuer shall make available a policy or certificate including only the following basic “core” package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

- (a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first (61st) day through the ninetieth (90th) day in any Medicare benefit period;
- (b) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
- (c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer’s payment as payment in full and may not bill the insured for any balance;
- (d) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
- (e) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(2) Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans B through J only as provided by Rule 0780-1-58-.09:

- (a) Medicare Part A Deductible. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.
- (b) Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first (21st) day through the one hundredth

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(100th) day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

- (c) Medicare Part B Deductible. Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
- (d) Eighty Percent (80%) of the Medicare Part B Excess Charges. Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
- (e) One Hundred Percent (100%) of the Medicare Part B Excess Charges. Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
- (f) Basic Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a \$250 calendar year deductible, to a maximum of \$1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.
- (g) Extended Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a \$250 calendar year deductible to a maximum of \$3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.
- (h) Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.
- (i) Preventive Medical Care Benefit. Coverage for the following preventive health services not covered by Medicare:
 - 1. An annual clinical preventive medical history and physical examination that may include tests and services from Subpart 2. of this Subparagraph (i) and patient education to address preventive health care measures;
 - 2. Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover

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the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

- (j) At-Home Recovery Benefit. Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

1. For purposes of this benefit, the following definitions shall apply:

- (i) “Activities of daily living” include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.
- (ii) “Care provider” means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.
- (iii) “Home” shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured’s place of residence.
- (iv) “At-home recovery visit” means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four-hour period of services provided by a care provider is one (1) visit.

2. Coverage Requirements and Limitations.

- (i) At-home recovery services provided must be primarily services which assist in activities of daily living.
- (ii) The insured’s attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.
- (iii) Coverage is limited to:
 - (I) No more than the number and type of at-home recovery visits certified as necessary by the insured’s attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;
 - (II) The actual charges for each visit up to a maximum reimbursement of forty dollars (\$40) per visit;

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- (III) \$1,600 per calendar year;
 - (IV) Seven (7) visits in any one (1) week;
 - (V) Care furnished on a visiting basis in the insured's home;
 - (VI) Services provided by a care provider as defined in this Rule;
 - (VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;
 - (VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.
3. Coverage is excluded for:
- (i) Home care visits paid for by Medicare or other government programs; and
 - (ii) Care provided by family members, unpaid volunteers or providers who are not care providers.
- (4) Standards for Plans K and L.
- (a) Standardized Medicare Supplement Benefit Plan K shall consist of the following:
- 1. Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first (61st) through the ninetieth (90th) day in any Medicare benefit period;
 - 2. Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first (91st) through the one hundred fiftieth (150th) day in any Medicare benefit period;
 - 3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
 - 4. Medicare Part A Deductible. Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (a)10. of this Paragraph;
 - 5. Skilled Nursing Facility Care. Coverage for fifty percent (50%) of the coinsurance amount for each day used from the twenty-first (21st) day

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through the one hundredth (100th) day in the Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (a)10. of this Paragraph;

6. Hospice Care. Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph (a)10. of this Paragraph;
7. Coverage for fifty percent (50%) under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph (a)10. of this Paragraph;
8. Except for coverage provided in Subparagraph (a)10. of this Paragraph, coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph (a)10. of this Paragraph;
9. Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and
10. Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand (\$4000) dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(b) Standardized Medicare Supplement Benefit Plan L shall consist of the following:

1. The benefits described in Subparagraphs (a)1., 2., 3. and 9. of this Paragraph;
2. The benefits described in Subparagraphs (a)4., 5., 6., 7. and 8. of this Paragraph, but substituting seventy-five percent (75%) for fifty percent (50%); and
3. The benefit described in Paragraph (a)10., but substituting \$2,000 for \$4,000.

Authority: T.C.A. § 56-7-1453(c) and (e).

0780-1-58-.09 STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS.

- (1) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in Rule 0780-1-58-.8(2).

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- (2) No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in Rule 0780-1-58-.09(7) and in Rule 0780-1-58-.10.
- (3) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans A through L listed in this Rule and conform to the definitions in Rule 0780-1-58-.04. Each benefit shall be structured in accordance with the format provided in Rule 0780-1-58-.08(2) and (3) or (4) and list the benefits in the order shown in this subsection. For purposes of this Rule, "structure, language, and format" means style, arrangement and overall content of a benefit.
- (4) An issuer may use, in addition to the benefit plan designations required in Paragraph (3) of this Rule, other designations to the extent permitted by law.
- (5) Make-up of benefit plans:
 - (a) Standardized Medicare Supplement Benefit Plan A shall be limited to the basic (core) benefits common to all benefit plans, as defined in Rule 0780-1-58-.08(2).
 - (b) Standardized Medicare Supplement Benefit Plan B shall include only the core benefit as defined in Rule 0780-1-58-.08(2), plus the Medicare Part A deductible as defined in Rule 0780-1-58-.08(3)(a).
 - (c) Standardized Medicare Supplement Benefit Plan C shall include only the core benefit as defined in Rule 0780-1-58-.08(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in Rule 0780-1-58-.08(3)(a), (b), (c) and (h) respectively.
 - (d) Standardized Medicare Supplement Benefit Plan D shall include only the core benefit (as defined in Rule 0780-1-58-.08(2)), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in Rule 0780-1-58-.08(3)(a), (b), (h) and (j) respectively.
 - (e) Standardized Medicare Supplement Benefit Plan E shall include only the following: The core benefit as defined in Rule 0780-1-58-.08(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in Rule 0780-1-58-.08(3)(a), (b), (h) and (i) respectively.
 - (f) Standardized Medicare Supplement Benefit Plan F shall include only the core benefit as defined in Rule 0780-1-58-.08(2), plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Rule 0780-1-58-.08(3)(a), (b), (c), (e) and (h) respectively.
 - (g) Standardized Medicare Supplement Benefit High Deductible Plan F shall include only one hundred percent (100%) of covered expenses following the payment of the annual High Deductible Plan F deductible. The covered expenses include the core benefit as defined in Rule 0780-1-58-.08(2), plus the Medicare Part A deductible,

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skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Rule 0780-1-58-.08(3)(a), (b), (c), (e) and (h) respectively. The annual High Deductible Plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare Supplement Benefit Plan F policy, and shall be in addition to any other specific benefit deductibles. The annual High Deductible Plan F deductible shall be \$1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12) month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10).

- (h) Standardized Medicare Supplement Benefit Plan G shall include only the core benefit as defined in Rule 0780-1-58-.08(2), plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in Rule 0780-1-58-.08(3)(a), (b), (d), (h) and (j) respectively.
- (i) Standardized Medicare Supplement Benefit Plan H shall consist of only the core benefit as defined in Rule 0780-1-58-.08(2), plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in Rule 0780-1-58-.08(3)(a), (b), (f) and (h) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.
- (j) Standardized Medicare Supplement Benefit Plan I shall consist of only the core benefit as defined in Rule 0780-1-58-.08(2), plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in Rule 0780-1-58-.08(3)(a), (b), (e), (f), (h) and (j) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.
- (k) Standardized Medicare Supplement Benefit Plan J shall consist of only the core benefit as defined in Rule 0780-1-58-.08(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in Rule 0780-1-58-.08(3)(a), (b), (c), (e), (g), (h), (i) and (j) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.
- (l) Standardized Medicare Supplement Benefit High Deductible Plan J shall consist of only one hundred percent (100%) of covered expenses following the payment of the annual High Deductible Plan J deductible. The covered expenses include the core benefit as defined in Rule 0780-1-58-.08(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Rule 0780-1-58-.08(3)(a), (b), (c), (e), (g), (h), (i) and (j) respectively. The annual High Deductible

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Plan J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare Supplement Plan J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10). The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

- (6) The make-up of the two (2) Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) shall be as follows:
 - (a) Standardized Medicare Supplement Benefit Plan K shall consist of only those benefits described in Rule 0780-1-58-.08(4)(a); and
 - (b) Standardized Medicare Supplement Benefit Plan L shall consist of only those benefits described in Rule 0780-1-58-.08(4)(b).
- (7) New or Innovative Benefits. An issuer may, with the prior approval of the Commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

Authority: T.C.A. § 56-7-1453(c), (d) and (e).

0780-1-58-.10 MEDICARE SELECT POLICIES AND CERTIFICATES.

- (1)
 - (a) This Rule shall apply to Medicare Select policies and certificates, as defined in this Rule.
 - (b) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this Rule.
- (2) For the purposes of this Rule:
 - (a) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.
 - (b) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.
 - (c) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

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- (d) "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.
 - (e) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.
 - (f) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.
 - (g) "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.
- (3) The Commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this Rule and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Commissioner finds that the issuer has satisfied all of the requirements of this Chapter.
- (4) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the Commissioner.
- (5) A Medicare Select issuer shall file a proposed plan of operation with the Commissioner in a format prescribed by the Commissioner. The plan of operation shall contain at least the following information:
- (a) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:
 - 1. Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.
 - 2. The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:
 - (i) To deliver adequately all services that are subject to a restricted network provision; or
 - (ii) To make appropriate referrals.
 - 3. There are written agreements with network providers describing specific responsibilities.
 - 4. Emergency care is available twenty-four (24) hours per day and seven (7) days per week.
 - 5. In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise

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seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This Subparagraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

- (b) A statement or map providing a clear description of the service area.
 - (c) A description of the grievance procedure to be utilized.
 - (d) A description of the quality assurance program, including:
 - 1. The formal organizational structure;
 - 2. The written criteria for selection, retention and removal of network providers; and
 - 3. The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.
 - (e) A list and description, by specialty, of the network providers.
 - (f) Copies of the written information proposed to be used by the issuer to comply with Paragraph (9) of this Rule.
 - (g) Any other information requested by the Commissioner.
- (6) (a) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the Commissioner prior to implementing the changes. Changes shall be considered approved by the Commissioner after thirty (30) days unless specifically disapproved.
- (b) An updated list of network providers shall be filed with the Commissioner at least quarterly.
- (7) A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:
- (a) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and
 - (b) It is not reasonable to obtain services through a network provider.
- (8) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.
- (9) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:
- (a) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:
 - 1. Other Medicare supplement policies or certificates offered by the issuer; and

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2. Other Medicare Select policies or certificates.
 - (b) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.
 - (c) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.
 - (d) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.
 - (e) A description of limitations on referrals to restricted network providers and to other providers.
 - (f) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.
 - (g) A description of the Medicare Select issuer's quality assurance program and grievance procedure.
- (10) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Paragraph (9) of this Rule and that the applicant understands the restrictions of the Medicare Select policy or certificate.
- (11) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.
 - (a) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.
 - (b) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.
 - (c) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.
 - (d) If a grievance is found to be valid, corrective action shall be taken promptly.
 - (e) All concerned parties shall be notified about the results of a grievance.
 - (f) The issuer shall report no later than each March 31st to the Commissioner regarding its grievance procedure. The report shall be in a format prescribed by the Commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

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- (12) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.
- (13)
 - (a) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.
 - (b) For the purposes of this Paragraph, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this Subparagraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.
- (14) Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this Rule should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.
 - (a) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.
 - (b) For the purposes of this Paragraph, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this Subparagraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.
- (15) A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

Authority: T.C.A. § 56-7-1453(e).

0780-1-58-.11 OPEN ENROLLMENT.

- (1) An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the

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first day of the first month in which an individual is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this Paragraph without regard to age.

- (2)
 - (a) If an applicant qualifies under Paragraph (1) of this Rule and submits an application during the time period referenced in Paragraph (1) of this Rule and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.
 - (b) If the applicant qualifies under Paragraph (1) of this Rule and submits an application during the time period referenced in Paragraph (1) of this Rule and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this Paragraph.
- (3) Except as provided in Paragraph (2) of this Rule and Rule 0780-1-58-.23, Paragraph (1) of this Rule shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

Authority: T.C.A. § 56-7-1453(b), (c) and (e).

0780-1-58-.12 GUARANTEED ISSUE FOR ELIGIBLE PERSONS.

- (1) Guaranteed Issue.
 - (a) Eligible persons are those individuals described in Paragraph (2) of this Rule who seek to enroll under the policy during the period specified in Paragraph (3) of this Rule, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.
 - (b) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Paragraph (5) of this Rule that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

- (2) Eligible Persons.

An eligible person is an individual described in any of the following Subparagraphs:

- (a) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual.

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- (b) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is sixty-five (65) years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:
1. The certification of the organization or plan has been terminated;
 2. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;
 3. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;
 4. The individual demonstrates, in accordance with guidelines established by the Secretary, that:
 - (i) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or
 - (ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
 5. The individual meets such other exceptional conditions as the Secretary may provide.
- (c)
1. The individual is enrolled with:
 - (i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);
 - (ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
 - (iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
 - (iv) An organization under a Medicare Select policy; and
 2. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Rule 0780-1-58-.12(2)(b).

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- (d) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:
 - 1. (i) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or
 - (ii) Of other involuntary termination of coverage or enrollment under the policy;
 - 2. The issuer of the policy substantially violated a material provision of the policy; or
 - 3. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.
 - (e)
 - 1. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select policy; and
 - 2. The subsequent enrollment under Subparagraph (e)1. of this Paragraph is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or
 - (f) The individual, upon first becoming eligible for benefits under Part A of Medicare at age sixty-five (65), enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.
 - (g) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Paragraph (4)(d) of this Rule.
- (3) Guaranteed Issue Time Periods.
- (a) In the case of an individual described in Paragraph (2)(a) of this Rule, the guaranteed issue period begins on the later of:
 - 1. The date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or

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2. The date that the applicable coverage terminates or ceases, and ends sixty-three (63) days thereafter.
 - (b) In the case of an individual described in Paragraphs (2)(b), (2)(c), (2)(e) or (2)(f) of this Rule whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated.
 - (c) In the case of an individual described in Paragraph (2)(d)1. of this Rule, the guaranteed issue period begins on the earlier of:
 1. The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; and
 2. The date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated.
 - (d) In the case of an individual described in Paragraphs (2)(b), (2)(d)2., (2)(d)3., (2)(e) or (2)(f) of this Rule who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date.
 - (e) In the case of an individual described in Paragraph (2)(g) of this Rule, the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty (60) day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D.
 - (f) In the case of an individual described in Paragraph (2) of this Rule but not described in the preceding provisions of this Paragraph, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.
- (4) Extended Medigap Access for Interrupted Trial Periods.
- (a) In the case of an individual described in Paragraph (2)(e) of this Rule (or deemed to be so described, pursuant to this Paragraph) whose enrollment with an organization or provider described in Paragraph (2)(e)1. of this Rule is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Rule 0780-1-58-.12(2)(e);
 - (b) In the case of an individual described in Paragraph (2)(f) of this Rule (or deemed to be so described, pursuant to this Paragraph) whose enrollment with a plan or in a program described in Paragraph (2)(f) of this Rule is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Rule 0780-1-58-.12(2)(f); and

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- (c) For purposes of Paragraphs (2)(e) and (2)(f) of this Rule, no enrollment of an individual with an organization or provider described in Paragraph(2)(e)2. of this Rule, or with a plan or in a program described in Paragraph (2)(f) of this Rule, may be deemed to be an initial enrollment under this Paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

(5) Products to Which Eligible Persons are Entitled.

The Medicare supplement policy to which eligible persons are entitled under:

- (a) Rule 0780-1-58-.12(2)(a), (b), (c) and (d) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.
- (b)
 - (i) Subject to Subpart (ii) of this Subparagraph, Rule 0780-1-58-.12(2)(e) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Subparagraph (a) of this Rule;
 - (ii) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this Paragraph is:
 - (I) The Policy available from the same issuer but modified to remove outpatient prescription drug coverage; or
 - (II) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer.
- (c) Rule 0780-1-58-.12(2)(f) shall include any Medicare supplement policy offered by any issuer.
- (d) Rule 0780-1-58-.12(2)(g) is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

(6) Notification provisions.

- (a) At the time of an event described in Paragraph (2) of this Rule because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this Rule, and of the obligations of issuers of Medicare supplement policies under Paragraph (1) of this Rule. Such notice shall be communicated contemporaneously with the notification of termination.
- (b) At the time of an event described in Paragraph (2) of this Rule because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the

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organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Rule 0780-1-58-.12(1). Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

Authority: T.C.A. § 56-7-1453(c).

0780-1-58-.13 STANDARDS FOR CLAIMS PAYMENT.

- (1) An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:
 - (a) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;
 - (b) Notifying the participating physician or supplier and the beneficiary of the payment determination;
 - (c) Paying the participating physician or supplier directly;
 - (d) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;
 - (e) Paying user fees for claim notices that are transmitted electronically or otherwise; and
 - (f) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.
- (2) Compliance with the requirements set forth in Paragraph (1) of this Rule shall be certified on the Medicare supplement insurance experience reporting form.

Authority: T.C.A. § 56-7-1453(d).

0780-1-58.14 LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM.

- (1) Loss Ratio Standards.
 - (a) 1. A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

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- (i) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or
 - (ii) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies.
 - 2. Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:
 - (i) Home office and overhead costs;
 - (ii) Advertising costs;
 - (iii) Commissions and other acquisition costs;
 - (iv) Taxes;
 - (v) Capital costs;
 - (vi) Administrative costs; and
 - (vii) Claims processing costs.
 - (b) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this Rule when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.
 - (c) Reserved.
 - (d) For policies issued prior to July 1, 1992 expected claims in relation to premiums shall meet:
 - 1. The originally filed anticipated loss ratio when combined with the actual experience since inception;
 - 2. The appropriate loss ratio requirement from Paragraphs (1)(a)1.(i) and (ii) when combined with actual experience beginning with April 28, 1996 to date; and
 - 3. The appropriate loss ratio requirement from Paragraphs (1)(a)1.(i) and (ii) over the entire future period for which the rates are computed to provide coverage.
- (2) Refund or Credit Calculation.

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- (a) An issuer shall collect and file with the Commissioner by May 31st of each year the data contained in the applicable reporting form contained in Appendix A to this Chapter for each type in a standard Medicare supplement benefit plan.
- (b) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.
- (c) For the purposes of this Rule, policies or certificates issued prior to July 1, 1992 the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after April 28, 1996. The first report shall be due by May 31, 1998.
- (d) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen (13) week Treasury notes. A refund or credit against premiums due shall be made by September 30th following the experience year upon which the refund or credit is based.

(3) Annual Filing of Premium Rates.

An issuer of Medicare supplement policies and certificates issued before or after the effective date of this Chapter in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the Commissioner in accordance with the filing requirements and procedures prescribed by the Commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the Commissioner, in accordance with the applicable filing procedures of this state:

- (a)
 - 1. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.
 - 2. An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the

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rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

3. If an issuer fails to make premium adjustments acceptable to the Commissioner, the Commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this Rule.

- (b) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

- (4) Public Hearings.

The Commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this Chapter if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the Commissioner.

Authority: T.C.A. §§ 56-2-301, 56-7-1453(e) and 56-7-1454.

0780-1-58-.15 FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES.

- (1) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the Commissioner in accordance with filing requirements and procedures prescribed by the Commissioner.
- (2) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.
- (3) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Commissioner in accordance with the filing requirements and procedures prescribed by the Commissioner.
- (4) (a) Except as provided in Subparagraph (b) of this Paragraph, an issuer shall not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

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- (b) An issuer may offer, with the approval of the Commissioner, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:
 - 1. The inclusion of new or innovative benefits;
 - 2. The addition of either direct response or agent marketing methods;
 - 3. The addition of either guaranteed issue or underwritten coverage; and
 - 4. The offering of coverage to individuals eligible for Medicare by reason of disability.
 - (c) For the purposes of this Rule, a “type” means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.
- (5) (a) Except as provided in Paragraph (1)(a) of this Rule, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this Chapter that has been approved by the Commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.
- 1. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the Commissioner in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the Commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.
 - 2. An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph (a)1. of this Paragraph shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the Commissioner of the discontinuance. The period of discontinuance may be reduced if the Commissioner determines that a shorter period is appropriate.
- (b) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this Paragraph.
 - (c) A change in the rating structure or methodology shall be considered a discontinuance under Subparagraph (a) of this Paragraph unless the issuer complies with the following requirements:
 - 1. The issuer provides an actuarial memorandum, in a form and manner prescribed by the Commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.
 - 2. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The Commissioner may approve a change to the differential which is in the public interest.

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- (6) (a) Except as provided in Subparagraph (b) of this Paragraph, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Rule 0780-1-58-.14.
- (b) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.
- (7) An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after the effective date of the amendment of this regulation based upon a structure or methodology with any groupings of attained ages greater than one (1) year. The ratio between rates for successive ages shall increase smoothly as age increases.

Authority: T.C.A. §§ 56-7-1453(d) and (e), and 56-7-1454.

0780-1-58-.16 PERMITTED COMPENSATION ARRANGEMENTS.

- (1) An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.
- (2) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.
- (3) No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.
- (4) For purposes of this Rule, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

Authority: T.C.A. § 56-7-1453(d).

0780-1-58-.17 REQUIRED DISCLOSURE PROVISIONS.

- (1) General Rules.
 - (a) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

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- (b) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.
 - (c) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary” or words of similar import.
 - (d) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as “Preexisting Condition Limitations.”
 - (e) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.
 - (f)
 - 1. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the NAIC and CMS and in a type size no smaller than twelve (12) point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this Chapter. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.
 - 2. For the purposes of this Rule, “form” means the language, format, type size, type proportional spacing, bold character, and line spacing.
- (2) Notice Requirements.
- (a) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the Commissioner. The notice shall:

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1. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and
 2. Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.
- (b) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.
- (c) The notices shall not contain or be accompanied by any solicitation.
- (3) MMA Notice Requirements.

Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

- (4) Outline of Coverage Requirements for Medicare Supplement Policies.
- (a) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant; and
- (b) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:
- NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.**
- (c) The outline of coverage provided to applicants pursuant to this section consists of four (4) parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All Plans A–L shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.
- (D) The following items shall be included in the outline of coverage in the order prescribed below:

Benefit Plans [insert letters of plans being offered]

The ☐

A. Some

plans may not be available in your state.

See Outlines of Coverage sections for details about ALL plans**Basic Benefits for Plans A - J:**

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Med ☐

Blood: First three (3) pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible	Part B Deductible				Part B Deductible	Part B Deductible
					Part B Excess (100%)	Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare						Preventive Care NOT covered by Medicare	Preventive Care NOT covered by Medicare

* Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year [\$1690] deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed [\$1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

[COMPANY NAME]
Outline of Medicare Supplement Coverage-Cover Page 2

Basic Benefits for Plans K and L include similar services as Plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	[\$4000] Out of Pocket Annual Limit***	[\$2000] Out of Pocket Annual Limit***

** Plans K and L provide for different cost-sharing for items and services than Plans A – J.

Once you reach ☐ . The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges”. You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

RULEMAKING HEARINGS

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within thirty (30) days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

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Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Rule 0780-1-58-.09(4).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[876] All but \$[219] a day All but \$[438] a day \$0 \$0	\$0 \$[219] a day \$[438] a day 100% of Medicare eligible expenses \$0	\$[876](Part A deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	 All approved amounts All but \$[109.50] a day \$0	 \$0 \$0 \$0	 \$0 Up to \$[109.50] a day All costs

RULEMAKING HEARINGS

PLAN A, MEDICARE (PART A), CONTINUED			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$[100] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs

RULEMAKING HEARINGS

PLAN A, MEDICARE (PART B), CONTINUED			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES			
	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

RULEMAKING HEARINGS

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[876] All but \$[219] a day All but \$[438] a day \$0 \$0	\$[876](Part A deductible) \$[219] a day \$[438] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[109.50] a day \$0	\$0 \$0 \$0	\$0 Up to \$[109.50] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

RULEMAKING HEARINGS

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints	\$0	All costs	\$0
Next \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

RULEMAKING HEARINGS

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[100] (Part B deductible) \$0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[876] All but \$[219] a day All but \$[438] a day \$0 \$0	\$[876](Part A deductible) \$[219] a day \$[438] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs

RULEMAKING HEARINGS

PLAN C, MEDICARE (PART A), CONTINUED			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[109.50] a day \$0	\$0 Up to \$[109.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

RULEMAKING HEARINGS

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$[100] (Part B deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$[100] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

RULEMAKING HEARINGS

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[100] of Medicare Approved Amounts*	\$0	\$[100] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—			
NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA	\$0	\$0	\$250
First \$250 each calendar year	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
Remainder of Charges			

RULEMAKING HEARINGS

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[876] All but \$[219] a day All but \$[438] a day \$0 \$0	\$[876] (Part A deductible) \$[219] a day \$[438] a day \$0 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[109.50] a day \$0	\$0 Up to \$[109.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as

RULEMAKING HEARINGS

provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$[100] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$[100] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
(continued)			

RULEMAKING HEARINGS

PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled			
care services and medical supplies	100%	\$0	\$0
—Durable medical equipment	\$0	\$0	\$[100] (Part B deductible)
First \$[100] of Medicare Approved Amounts*	80%	20%	\$0
Remainder of Medicare Approved Amounts			
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan	\$0	Actual charges to \$40 a visit	Balance
—Benefit for each visit			
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	

RULEMAKING HEARINGS

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

PLAN E

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[876] All but \$[219] a day All but \$[438] a day \$0 \$0	\$[876] (Part A deductible) \$[219] a day \$[438] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs

RULEMAKING HEARINGS

PLAN E, MEDICARE (PART A), CONTINUED			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$[109.50] a day \$0	\$0 Up to \$[109.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

RULEMAKING HEARINGS

PLAN E

MEDICARE (PART B)—MEDICAL SERVICES—PER BENEFIT PERIOD

* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$[100] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$[100] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

RULEMAKING HEARINGS

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$[100] (Part B deductible) \$0

PLAN E

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
*PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All costs

*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

RULEMAKING HEARINGS

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
 [**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[1690] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1690] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90 th day 91st day and after: While using 60 Lifetime reserve days Once lifetime reserve days Are used: Additional 365 days Beyond the additional 365 days	All but \$[876] All but \$[219] a day All but \$[438] a day \$0 \$0	\$[876] (Part A deductible) \$[219] a day \$[438] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101 st day and after	All approved amounts All but \$[109.50] a day \$0	\$0 Up to \$[109.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

RULEMAKING HEARINGS

PLAN F or HIGH DEDUCTIBLE PLAN F, MEDICARE (PART A), CONTINUED			
SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1690] DEDUCTIBLE,**] YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

***** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[1690] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

RULEMAKING HEARINGS

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1690] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, Such as physician's Services, inpatient and Outpatient medical and Surgical services and Supplies, physical and Speech therapy, Diagnostic tests, Durable medical Equipment, First \$[100] of Medicare Approved amounts* Remainder of Medicare Approved amounts	 \$0 Generally 80%	 \$[100] (Part B deductible) Generally 20%	 \$0 \$0
Part B excess charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[100] of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$[100] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

RULEMAKING HEARINGS

PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[1690] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[1690] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment	100%	\$0	\$0
First \$[100] of	\$0	\$[100] (Part B deductible)	\$0
Medicare approved Amounts*	80%	20%	\$0
Remainder of Medicare approved Amounts			

RULEMAKING HEARINGS
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[1690] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[1690] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

RULEMAKING HEARINGS

PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[876] All but \$[219] a day All but \$[438] a day \$0 \$0	\$[876] (Part A deductible) \$[219] a day \$[438] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[109.50] a day \$0	\$0 Up to \$[109.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as

RULEMAKING HEARINGS

provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$[100] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	80%	20%
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$[100] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

RULEMAKING HEARINGS

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES —NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	

RULEMAKING HEARINGS

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maxi-mum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

RULEMAKING HEARINGS

PLAN H

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[876] All but \$[219] a day All but \$[438] a day \$0 \$0	\$[876] (Part A deductible) \$[219] a day \$[438] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[109.50] a day \$0	\$0 Up to \$[109.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as

RULEMAKING HEARINGS

provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN H

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES —IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$[100] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	0%	All Costs
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$[100] (Part B deductible) \$0

RULEMAKING HEARINGS

PLAN H, MEDICARE (PART B), CONTINUED			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
CLINICAL LABORATORY SERVICES —TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment First \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN H

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL — NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum

RULEMAKING HEARINGS

PLAN I

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[876] All but \$[219] a day All but \$[438] a day \$0 \$0	\$[876] (Part A deductible) \$[219] a day \$[438] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[109.50] a day \$0	\$0 Up to \$[109.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

RULEMAKING HEARINGS

PLAN I

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$[100] (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[100] (Part B deductible) \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

RULEMAKING HEARINGS

PLAN I

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES —NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
—Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare-approved visits, not to exceed 7 each week	
—Calendar year maximum	\$0	\$1,600	

RULEMAKING HEARINGS

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	 \$0 \$0	 \$0 80% to a lifetime maxi-mum benefit of \$50,000	 \$250 20% and amounts over the \$50,000 lifetime maximum

RULEMAKING HEARINGS

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
 [** This high deductible plan pays the same benefits as Plan J after one has paid a calendar year \$[1690] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are \$[1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1690] DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91 st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[876] All but \$[219] a day All but \$[438] a day \$0 \$0	\$[876] (Part A deductible) \$[219] a day \$[438] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[109.50] a day \$0	\$0 Up to \$[109.50] a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

(continued)

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

RULEMAKING HEARINGS

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan J after one has paid a calendar year \$[1690] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are \$[1690]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[1690] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO \$[1690] DEDUCTIBLE,**] YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$[100] (Part B deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$[100] (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

RULEMAKING HEARINGS

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[1690] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[1690] DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$[100] (Part B deductible) 20%	\$0 \$0 \$0
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit —Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit) —Calendar year maximum	\$0 \$0 \$0	Actual charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week \$1,600	Balance

(continued)

RULEMAKING HEARINGS

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[1690] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[1690] DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maxi-mum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
***PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All costs

***Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

RULEMAKING HEARINGS

PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[876] All but \$[219] a day All but \$[438] a day \$0 \$0	\$[438](50% of Part A deductible) \$[219] a day \$[438] a day 100% of Medicare eligible expenses \$0	\$[438](50% of Part A deductible)♦ \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[109.50] a day \$0	\$0 Up to \$[54.75] a day \$0	\$0 Up to \$[54.75] a day ♦ All costs

RULEMAKING HEARINGS

MEDICARE (PART A), CONTINUED			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
BLOOD First 3 pints Additional amounts	\$0 100%	50% \$0	50%♦ \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	50% of coinsurance or copayments	50% of coinsurance or copayments♦

(continued)

***** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

RULEMAKING HEARINGS

PLAN K

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[100] of Medicare Approved Amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$0 Generally 75% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 10%	\$[100] (Part B deductible)**** ♦ All costs above Medicare approved amounts Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$4000])*
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50%♦ \$[100] (Part B deductible)**** ♦ Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[4000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

RULEMAKING HEARINGS

PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[100] of Medicare Approved Amounts*****	\$0	\$0	\$[100] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10%♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

RULEMAKING HEARINGS

PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[2000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the additional 365 days	All but \$[876] All but \$[219] a day All but \$[438] a day \$0 \$0	\$[657] (75% of Part A deductible) \$[219] a day \$[438] a day 100% of Medicare eligible expenses \$0	\$[219] (25% of Part A deductible)♦ \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility Within 30 days after leaving the hospital First 20 days 21 st thru 100th day 101st day and after	All approved amounts All but \$[109.50] a day \$0	\$0 Up to \$[82.13] a day \$0	\$0 Up to \$[27.37] a day♦ All costs
BLOOD First 3 pints Additional amounts	\$0 100%	75% \$0	25%♦ \$0

RULEMAKING HEARINGS

PLAN L, MEDICARE (PART A), CONTINUED			
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	Generally, most Medicare eligible expenses for out-patient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments ♦

(continued)

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

RULEMAKING HEARINGS

PLAN L

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

**** Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[100] of Medicare Approved Amounts****	\$0	\$0	\$[100] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$2000])*
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts****	\$0 \$0	75% \$0	25%♦ \$[100] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2000] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

RULEMAKING HEARINGS

PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[100] of Medicare Approved Amounts*****	\$0	\$0	\$[100] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5% ♦

- (5) *****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.(6) Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

- (a) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Sections 1395, *et seq.*), disability income policy, or other policy identified in Rule 0780-1-58-.03(2), issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

“THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.”

- (b) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Paragraph (4)(a) of this Rule shall disclose, using the applicable statement in Appendix C to this Chapter, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a ***part of, or together with, the application for the policy or certificate.***

Authority: T.C.A. §§ 56-7-1453(e), and 56-7-1455(b) and (d).

RULEMAKING HEARINGS

0780-1-58-.18 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.

- (1) Application forms shall include the statements and questions set forth in Appendix D of this Chapter designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.
- (2) Producers shall list the following health insurance policies they have sold to the applicant:
 - (a) All policies sold to the applicant which are still in force; and
 - (b) All policies sold to the applicant in the past five (5) years which are no longer in force.
- (3) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.
- (4) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its producer, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the producer, except where the coverage is sold without a producer, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.
- (5) The notice required by Paragraph (4) of this Rule for an issuer shall be provided in a substantially similar form to Appendix E of this Chapter in no less than twelve (12) point type:
- (6) Paragraphs 1 and 2 of Appendix E (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

Authority: T.C.A. §§ 56-7-1453(c) and (d), and 56-7-1455(e).

0780-1-58-.19 FILING REQUIREMENTS FOR ADVERTISING.

An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the Commissioner for review or approval by the Commissioner.

Authority: T.C.A. §§ 56-7-1431 and 1457.

RULEMAKING HEARINGS

0780-1-58-.20 STANDARDS FOR MARKETING.

- (1) An issuer, directly or through its producers, shall:
 - (a) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.
 - (b) Establish marketing procedures to assure excessive insurance is not sold or issued.
 - (c) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

“Notice to buyer: This policy may not cover all of your medical expenses.”
 - (d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.
 - (e) Establish auditable procedures for verifying compliance with this Paragraph.
- (2) In addition to the practices prohibited in T.C.A. § 56-8-104, the following acts and practices are unfair and/or deceptive, and, thus, prohibited:
 - (a) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer.
 - (b) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.
 - (c) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.
- (3) The terms “Medicare Supplement,” “Medigap,” “Medicare Wrap-Around” and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

Authority: T.C.A. §§ 56-7-1429, 1431, 1453(d), and 56-8-113.

0780-1-58-.21 APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE.

- (1) In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

RULEMAKING HEARINGS

- (2) Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.
- (3) An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

Authority: *T.C.A. § 56-7-1453(c) and (d).*

0780-1-58-.22 REPORTING OF MULTIPLE POLICIES.

- (1) On or before March 1st of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:
 - (a) The policy and certificate number; and
 - (b) Each policy or certificate's date of issuance.
- (2) The items set forth above must be grouped by individual policyholder.

Authority: *T.C.A. § 56-7-1453(d).*

0780-1-58-.23 PROHIBITION AGAINST PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.

- (1) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy.
- (2) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

Authority: *T.C.A. § 56-7-1453(c).*

0780-1-58-.24 SEVERABILITY.

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

Authority: *T.C.A. §§ 56-2-301, 56-7-1425 through 1430, and 56-7-1451 through 56-7-1459.*

RULEMAKING HEARINGS

0780-1-58-.25 EFFECTIVE DATE.

Unless other wise provided in this Chapter, this Chapter shall be effective as provided for by the Uniform Administrative Procedures Act, compiled in T.C.A. title 4, chapter 5.

Authority: T.C.A. §§ 56-2-301, 56-7-1425 through 1430, and 56-7-1451 through 56-7-1459.

APPENDIX A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR _____

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

Line		(a) Earned Premium ³	(b) Incurred Claims ⁴
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues ⁵		
	c. Net (for reporting purposes = 1a-1b)		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		
4.	Refunds Last Year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception (see worksheet for Ratio 1)		
8.	Experienced Ratio Since Inception (Ratio 2) <div style="text-align: right;"> Total Actual Incurred Claims (line 3, col. b) Total Earned Prem. (line 3, col. a)-Refunds Since Inception (line 6) </div>		
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10.	Tolerance Permitted (obtained from credibility table)		

Medicare Supplement Credibility Table

Life Years Exposed	
Since Inception	Tolerance
10,000 +	0.0%

RULEMAKING HEARINGS

5,000 -9,999	5.0%
2,500 -4,999	7.5%
1,000 -2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

- 1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only
 2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for prestandardized plans
 3 Includes Modal Loadings and Fees Charged
 4 Excludes Active Life Reserves
 5 This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR_____

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

11. Adjustment to Incurred Claims for Credibility
 Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.
 If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6)] x Ratio 3 (line 11)
13.	Refund = Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6) –[Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1)]

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature

Name - Please Type

Title - Please Type

Date

RULEMAKING HEARINGS

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES FOR CALENDAR YEAR _____

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

(a) ³	(b) ⁴ Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(o) ⁵ Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+ ⁶		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: $(l + n)/(k + m)$: _____

- ¹ Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
- ² "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
- ³ Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.).
- ⁴ F ☐
- ⁵ These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
- ⁶ To include the earned premium for all years prior to as well as the 15th year prior to the current year.

RULEMAKING HEARINGS

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES FOR CALENDAR YEAR _____

TYPE¹ _____ SMSBP² _____

For the State of _____ Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____ Person Completing Exhibit _____

Title _____ Telephone Number _____

(a) ³	(b) ⁴ Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(o) ⁵ Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+ ⁶		4.175		0.493		8.684		0.725		0.77
Total:			(k):	(l):	(m):		(n):			

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

¹ Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

² "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

³ Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.).

⁴ F

⁵ These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

⁶ To include the earned premium for all years prior to as well as the 15th year prior to the current year.

RULEMAKING HEARINGS

**APPENDIX B
FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES**

Company Name: _____

Address: _____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

Signature

Name and Title (please type)

Date

RULEMAKING HEARINGS

APPENDIX C

DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882(d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

RULEMAKING HEARINGS

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>
--

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

<p>Before You Buy This Insurance</p>

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

RULEMAKING HEARINGS

[Original disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

RULEMAKING HEARINGS

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>
--

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

<p>Before You Buy This Insurance</p>

√

Check the coverage in **all** health insurance policies you already have.

- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

RULEMAKING HEARINGS

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

RULEMAKING HEARINGS

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- hospice
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

RULEMAKING HEARINGS

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>
--

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items & services

<p>Before You Buy This Insurance</p>

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

RULEMAKING HEARINGS

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>
--

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

<p>Before You Buy This Insurance</p>

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

RULEMAKING HEARINGS

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>
--

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

<p>Before You Buy This Insurance</p>

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

RULEMAKING HEARINGS

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

RULEMAKING HEARINGS

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>
--

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

<p>Before You Buy This Insurance</p>

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

RULEMAKING HEARINGS

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>
--

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

<p>Before You Buy This Insurance</p>

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

RULEMAKING HEARINGS

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>
--

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

<p>Before You Buy This Insurance</p>

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

RULEMAKING HEARINGS

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>
--

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items & services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

<p>Before You Buy This Insurance</p>

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

RULEMAKING HEARINGS

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</p>
--

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

<p>Before You Buy This Insurance</p>

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or your state senior insurance counseling program.

RULEMAKING HEARINGS

APPENDIX D

STATEMENTS AND QUESTIONS TO BE INCLUDED IN APPLICATION FORMS

STATEMENTS

- (1) You do not need more than one Medicare supplement policy.
- (2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- (3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- (4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

QUESTIONS

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X"]

RULEMAKING HEARINGS

To the best of your knowledge,

- (1) (a) Did you turn age sixty-five (65) in the last six (6) months?

Yes____ No____

- (b) Did you enroll in Medicare Part B in the last six (6) months?

Yes____ No____

- (c) If yes, what is the effective date? _____

- (2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes____ No____

If yes,

- (a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes____ No____

- (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes____ No____

- (3) (a) If you had coverage from any Medicare plan other than original Medicare within the past sixty-three (63) days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes____ No____

- (c) Was this your first time in this type of Medicare plan?

Yes____ No____

- (d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes____ No____

RULEMAKING HEARINGS

- (4) (a) Do you have another Medicare supplement policy in force?

Yes____ No____

- (b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

- (c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes____ No____

- (5) Have you had coverage under any other health insurance within the past sixty-three (63) days? (For example, an employer, union, or individual plan)

Yes____ No____

- (a) If so, with what company and what kind of policy?

- (b) What are your dates of coverage under the other policy?

START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank.)

RULEMAKING HEARINGS

APPENDIX E

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- ____ Additional benefits.
- ____ No change in benefits, but lower premiums.
- ____ Fewer benefits and lower premiums.
- ____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
[optional only for Direct Mailers.]
- _____
- _____
- ____ Other. (please specify) _____
- ____

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the

RULEMAKING HEARINGS

new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

(Signature of Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

The notice of rulemaking set out herein was properly filed in the Department of State on the 29th day of July, 2005. (07-51)

RULEMAKING HEARINGS

DEPARTMENT OF COMMERCE AND INSURANCE - 0780 DIVISION OF INSURANCE

There will be a hearing before the Commissioner of Commerce and Insurance to consider the promulgation of rules pursuant to Tenn. Code Ann. § 56-7-2814. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tenn. Code Ann. § 4-5-204 and will take place in Fifth Floor, Conference Room A of the Davy Crockett Tower located at 500 James Robertson Parkway in Nashville, Tennessee at 10:00 a.m. CST on the 15th day of September, 2005.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Department of Commerce and Insurance to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings), to allow time for the Department to determine how it may reasonably provide such aid or service. Initial contact may be made with Don Coleman, the Department's ADA Coordinator, at 500 James Robertson Parkway, Fifth Floor, Nashville, Tennessee 37243, telephone (615) 741-0481.

For a copy of this notice of rulemaking hearing, contact: John F. Morris, Staff Attorney, Department of Commerce and Insurance, Davy Crockett Tower, Fifth Floor, 500 James Robertson Parkway, Nashville, Tennessee 37243, telephone (615) 741-2199.

SUBSTANCE OF PROPOSED RULES

CHAPTER 0780-1-88

TENNESSEE HEALTH INSURANCE PORTABILITY, AVAILABILITY AND RENEWABILITY REGULATIONS

NEW RULES

TABLE OF CONTENTS

- 0780-1-88-.01 Purpose and Scope
- 0780-1-88-.02 Definitions
- 0780-1-88-.03 Producer Compensation
- 0780-1-88-.04 Penalties
- 0780-1-88-.05 Severability

0780-1-88-.01 PURPOSE AND SCOPE.

The purpose of this Chapter is to implement regulations necessary to ensure compliance with the federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified as amended in scattered sections in 42 U.S.C.), and to implement the minimum standards established by such Act, as well as to implement regulations necessary to carry out the proper administration of the Tennessee Health Insurance Portability, Availability and Renewability Act, T.C.A. §§ 56-7-2801, *et seq.*

Authority: T.C.A. §§ 56-7-2801, *et seq.*, and 56-7-2814, and Pub.L. 104-191, 110 Stat. 1936 (1996).

RULEMAKING HEARINGS

0780-1-88-.02 DEFINITIONS

- (1) "Compensation" means any consideration given or promised by a health insurance issuer to its producers for the sale of contracts providing health insurance coverage, including but not limited to commissions, bonuses, or other such rewards;
- (2) "Group health plan" means an employee welfare benefit plan, as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, to the extent that the plan provides medical care and including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise. A program under which creditable coverage is provided shall be treated as a group health plan for the purposes of applying this Chapter;
- (3) "Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any policy, certificate, or agreement offered by a health insurance issuer;
- (4) "Health insurance issuer" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide health insurance coverage, including but not limited to, an insurance company, a health maintenance organization and a nonprofit hospital and medical service corporation. "Health insurance issuer" does not mean a group health plan;
- (5) "HIPAA" means the federal Health Insurance Portability and Accountability Act of 1996, Pub.L. 104-191, 110 Stat. 1936 (1996), and the Tennessee Health Insurance Portability, Availability and Renewability Act, T.C.A. §§ 56-7-2801, *et seq.*;
- (6) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan. This includes coverage offered in connection with a group health plan that has fewer than two (2) participants as current employees on the first day of the plan year;
- (7) "Producer" means a person required to be licensed pursuant to T.C.A. title 56, chapter 6, part 1 to sell, solicit or negotiate insurance on behalf of a health insurance issuer in this state.

Authority: T.C.A. §§ 56-7-2802 and 56-7-2814.

0780-1-88-.03 PRODUCER COMPENSATION.

The compensation paid by a health insurance issuer to its producers for a policy of insurance required to be offered by health insurance issuers under HIPAA shall not be less than the compensation paid to its producers for the health insurance issuer's standard health insurance products.

Authority: T.C.A. §§ 56-7-2814, 56-8-104(6) and 56-8-113, Pub.L. 104-191, 110 Stat. 1936 (1996), 45 C.F.R. §146.150(a), and 45 C.F.R. §148.120.

RULEMAKING HEARINGS

0780-1-88-.04 PENALTIES.

In addition to any other law or penalty that may apply, violations of 0780-1-88-.03 shall be treated as unfair discrimination and an unfair act or practice under T.C.A. § 56-8-104(6)(B), and shall subject the health insurance issuer to the penalties set forth in T.C.A. § 56-8-109.

Authority: T.C.A. §§ 56-7-2814, 56-8-104(6) and 56-8-113.

0780-1-88-.05 SEVERABILITY.

If any provision of this Chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

Authority: T.C.A. §§ 56-7-2814 and 56-8-113.

The notice of rulemaking set out herein was properly filed in the Department of State on the 27th day of July, 2005. (07-27).

RULEMAKING HEARINGS

DEPARTMENT OF ENVIRONMENT AND CONSERVATION - 0780 DIVISION OF UNDERGROUND STORAGE TANKS

The Tennessee Petroleum Underground Storage Tank Board will hold public hearings to receive comments concerning amendments to the Rules of the Department of Environment and Conservation Division of Underground Storage Tanks Chapter 1200-1-15 Underground Storage Tank program pursuant to T.C.A. § 68-215-113. These hearings will be conducted as prescribed by the Uniform Administrative Procedures Act T.C.A. § 4-5-201 et. seq.

The first hearing will take place in the 17th Floor Conference Room at the L & C Tower, 401 Church Street, Nashville, Tennessee at 1:00 P.M. CST on Monday, September 19, 2005.

The second hearing will take place in the Ayers Auditorium in the McWherter Center at Jackson State Community College, 2046 North Parkway (Highway 412), Jackson, Tennessee at 9:00 A.M.. CST on Friday, September 23, 2005.

The third such hearing will take place in the Community Room at the Knox County Health Department, 140 Dameron Avenue, Knoxville 37917 at 9:00 A.M. EST on Tuesday, September 27, 2005.

Written comments will be considered if received by close of business, October 14, 2005, at the office of the Technical Secretary, Tennessee Petroleum Underground Storage Tank Board, 4th Floor, L & C Tower, 401 Church Street, Nashville, Tennessee 37243-1531.

Individuals with disabilities wishing to participate in these proceedings (or to review these filings) should contact the Tennessee Department of Environment and Conservation to discuss any auxiliary aids or services needed to facilitate such participation. Such contact may be in person, by writing, telephone, or other means and should be made no less than ten days prior to the date of the hearing or the date such party intends to review such filings, to allow time to provide such aid or service. Contact the Tennessee Department of Environment and Conservation Kim McCrary, ADA Coordinator, 12th Floor, L & C Tower, 401 Church Street, Nashville, Tennessee 37243-0437, 615-532-0211.

For complete copies of the text of the notice, please contact Donna Washburn, Tennessee Department of Environment and Conservation, Division of Underground Storage Tanks, 4th Floor, L & C Tower, 401 Church Street, Nashville, Tennessee 37243-1531, 615-532-0987. Copies may also be obtained at the Environmental Assistance Centers for the Department of Environment and Conservation, which can be reached by calling 1-888-891-TDEC(8332). The notice and copies of the proposed rules are posted on the web site for the Division of Underground Storage Tanks, <http://www.state.tn.us/environment/ust>.

SUBSTANCE OF PROPOSED RULES

Paragraph (3) Definitions of rule 1200-1-15-.01 Program Scope and Minimum Requirements for Tanks is amended by inserting the following definitions in alphabetical order and renumbering the definitions accordingly:

“Containment sump” means a liquid-tight compartment that provides containment of any product releases. Containment sumps are typically used underneath product dispensers and/or for enclosing the submersible turbine pump and piping connections at the top of an underground storage tank.

“Continuous In-Tank Leak Detection System” means a release detection system that allows an underground storage tank to operate continuously or nearly continuously without interruption for release detection tests. However, the system may default to a standard or shut down test, requiring

RULEMAKING HEARINGS

the tank to be taken briefly out of service at the end of the month if sufficient good data has not been obtained over the month. These methods include Continuous Automatic Tank Gauging Systems and Continual Reconciliation Systems.

“Dispenser” means a device that discharges petroleum products from underground storage tanks into tanks in motorized vehicles, equipment tanks, or other containers, while simultaneously measuring the amount of petroleum dispensed.

“Flexible piping” means piping constructed of flexible thermoplastic material that is typically installed in one continuous run with no inaccessible joints.

“Secondary containment” means a system designed and installed so that any material that is released from the primary containment is prevented from reaching the soil or groundwater outside the system.

“Submersible Turbine Pump” or “STP” means pump located inside a petroleum underground storage tank, positioned near the bottom of the tank, thereby “submerged” in the petroleum.

Paragraph (8) Scope of Fund Coverage of rule 1200-1-15-.09 is amended as follows:

Subparagraph (b) is amended by deleting “parts 1., 2., or 3.” And replacing it with “parts 1 through 6”.

Subparagraph (b) is further amended by the addition of Part 6 as set forth below:

6. If the date of the release was on or after July 1, 2005, the financial responsibility requirements for fund eligible owners or operators or petroleum site owners for taking corrective action shall be twenty thousand dollars (\$20,000) and compensation of third parties shall be twenty thousand dollars (\$20,000).

Subparagraph (8)(b) is further amended by adding the following row to the bottom of Table 3, Owner/Operator Financial Responsibility per Site per Occurrence:

On or After July 1, 2005	\$20,000 Clean-up/ \$20,000 third party	\$20,000 Clean-up/ \$20,000 third party	\$20,000 Clean-up/ \$20,000 third party
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A new Subparagraph (d) is added as follows:

- (d) If the date of the release is on or after September 1, 2005, the owner and/or operator may apply for a reduction of the financial responsibility requirement for corrective action set forth in part (b)6. of this paragraph. Application shall be made using a format established by the division and in accordance with instructions provided by the division.
 1. The tank owner and/or operator must demonstrate to the satisfaction of the division that each UST system at the facility meets or exceeds the criteria for reduction of the financial responsibility amount set forth in the table in this subparagraph. Such demonstration may include, but not be limited to:
 - (i) Submittal of verifying documentation to the division; and/or

RULEMAKING HEARINGS

(ii) On-site verification by the division.

2. For each criterion met there shall be an associated reduction in the financial responsibility amount. However, the maximum percentage reduction in the financial responsibility amount per occurrence shall not exceed fifty percent (50 %).

CRITERIA	PERCENTAGE REDUCTION
Double Wall Tank(s)	10 %
Secondary Containment Chase Piping Enclosing Fiberglass Primary Piping or Flexible Plastic Piping with Containment Sumps at Piping Joints	10 %
Containment Sumps at Submersible Turbine Pumps	10 %
Containment Sumps under Dispensers	10 %
Continuous In-Tank Leak Detection System	10 %

3. If a criterion is not applicable to one or more of the UST systems at the facility, then the conditions of part 1 of this subparagraph shall have been met if every UST systems at the facility for which the criterion is applicable meets that criterion. For example, the criterion for a containment sump under a dispenser is not applicable to a UST system used to store waste oil or used oil.
4. Upon confirmation by the division that a tank owner and/or operator has met one or more of the criteria for reduction of the financial responsibility amount set forth in the table in this subparagraph, the tank owner and/or operator will be sent correspondence setting forth the new reduced financial responsibility amount.

The notice of rulemaking set out herein was properly filed in the Department of State on the 27th day of July, 2005. (07-34)

RULEMAKING HEARINGS

DEPARTMENT OF ENVIRONMENT AND CONSERVATION - 0400 DIVISION OF UNDERGROUND STORAGE TANKS

The Tennessee Petroleum Underground Storage Tank Board will hold public hearings to receive comments concerning amendments to the Rules of the Department of Environment and Conservation Division of Underground Storage Tanks Chapter 1200-1-15 Underground Storage Tank program pursuant to T.C.A. § 68-215-113. These hearings will be conducted as prescribed by the Uniform Administrative Procedures Act T.C.A. § 4-5-201 et. seq.

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Individuals with disabilities wishing to participate in these proceedings (or to review these filings) should contact the Tennessee Department of Environment and Conservation to discuss any auxiliary aids or services needed to facilitate such participation. Such contact may be in person, by writing, telephone, or other means and should be made no less than ten days prior to the date of the hearing or the date such party intends to review such filings, to allow time to provide such aid or service. Contact the Tennessee Department of Environment and Conservation Kim McCrary, ADA Coordinator, 12th Floor, L & C Tower, 401 Church Street, Nashville, Tennessee 37243-0437, 615-532-0211.

For complete copies of the text of the notice, please contact Donna Washburn, Tennessee Department of Environment and Conservation, Division of Underground Storage Tanks, 4th Floor, L & C Tower, 401 Church Street, Nashville, Tennessee 37243-1531, 615-532-0987. Copies may also be obtained at the Environmental Assistance Centers for the Department of Environment and Conservation, which can be reached by calling 1-888-891-TDEC(8332). The notice and copies of the proposed rules are posted on the web site for the Division of Underground Storage Tanks, <http://www.state.tn.us/environment/ust>.

RULEMAKING HEARINGS

SUBSTANCE OF THE PROPOSED RULE

The Table of Contents for Chapter 1200-1-15 is being amended by deleting it in its entirety and replacing it with the following:

TABLE OF CONTENTS

1200-1-15-.01	Program Scope, Definitions and Proprietary Information	1200-1-15-.07	Out-of-Service UST Systems and Closure
1200-1-15-.02	UST System: Installation and Operation	1200-1-15-.08	Financial Responsibility
1200-1-15-.03	Notification, Reporting and Record Keeping	1200-1-15-.09	Administrative Guidelines and Procedures for the Tennessee Petroleum Underground Storage Tank Fund
1200-1-15-.04	Release Detection		
1200-1-15-.05	Release Reporting, Investigation, and Confirmation	1200-1-15-.10	Fee Collection and Certificate Issuance
1200-1-15-.06	Petroleum Release Response Remediation and Risk Management	1200-1-15-.11	Appeals
		1200-1-15-.12	Indicia of Ownership

Rule 1200-1-15-.01 Program Scope and Minimum Requirements for Tanks is amended by deleting it in its entirety and replacing it with the following:

1200-1-15-.01 PROGRAM SCOPE, DEFINITIONS AND PROPRIETARY INFORMATION .

- (1) Program Scope: General
 - (a) Purpose, Scope, and Applicability - This rule provides definitions of terms, general standards and procedures, as well as overview information applicable to these rules.
 - (b) Use of Number and Gender - As used in these rules:
 - 1. Words in the masculine gender also include the feminine and neuter genders; and
 - 2. Words in the singular include the plural; and
 - 3. Words in the plural include the singular.
 - (c) Rule Structure - These rules are organized, numbered, and referenced according to the following outline form:
 - (1) paragraph
 - (a) subparagraph
 - 1. part
 - (i) subpart
 - (I) item
 - I. subitem

RULEMAKING HEARINGS

A. section

(A) subsection

(2) Program Scope: Applicability.

- (a) The requirements of this chapter apply to all owners and/or operators of an UST system as defined in paragraph (4) of this rule except as otherwise provided in subparagraph (b) and (c) of this paragraph. Any UST systems listed in subparagraph (b) of this paragraph shall meet the requirements of paragraph (3) of this rule.
- (b) Deferrals. Rules 1200-1-15-.02 through 1200-1-15-.05 and 1200-1-15-.07 through 1200-1-15-.10 do not apply to any of the following types of UST systems:
 - 1. Wastewater treatment tank systems;
 - 2. Any UST systems containing radioactive material that are regulated under the Atomic Energy Act of 1954 (42 USC 2011 and following);
 - 3. Any UST system that is part of an emergency generator system at nuclear power generation facilities regulated by the Nuclear Regulatory Commission under 10 CFR Part 50, Appendix A;
 - 4. Airport hydrant fuel distribution systems; and
 - 5. UST systems with field-constructed tanks.
 - 6. Equipment or machinery that contains petroleum for operational purposes such as hydraulic lift tanks and electrical equipment tanks.
 - 7. Any UST system whose capacity is 110 gallons or less.
 - 8. Any UST system that contains a de minimis concentration of petroleum.
 - 9. Any emergency spill or overflow containment UST system that is expeditiously emptied after use.
- (c) Deferrals. Release detection requirements in rule 1200-1-15-.04 do not apply to any UST system that stores fuel solely for use by emergency power generators.

(3) Interim prohibition for deferred UST systems.

- (a) No person may install an UST system for the purpose of storing petroleum unless the UST system (whether of single or double-wall construction):
 - 1. Will prevent releases due to corrosion or structural failure for the operational life of the UST system;
 - 2. Is cathodically protected against corrosion, constructed of noncorrodible material, steel clad with a noncorrodible material, or designed in a manner to prevent the release or threatened release of any petroleum; and
 - 3. Is constructed or lined with material that is compatible with the

RULEMAKING HEARINGS

petroleum.

- (b) Notwithstanding subparagraph (a) of this paragraph, an UST system without corrosion protection may be installed at a site that is determined by a corrosion expert not to be corrosive enough to cause it to have a release due to corrosion during its operating life. Owners and operators shall maintain records that demonstrate compliance with the requirements of this subparagraph for the remaining life of the tank.

(4) Definitions.

“Aboveground release” means any release to the surface of the land or to surface water. This includes, but is not limited to, releases from the above-ground portion of an UST system and aboveground releases associated with overfills and transfer operations as the petroleum moves to or from an UST system.

“Access” means the ability and opportunity to gain knowledge of Proprietary Information in any manner whatsoever.

“Accidental release” means any sudden or nonsudden release of petroleum from an underground storage tank that results in a need for corrective action and/or compensation for bodily injury or property damage neither expected nor intended by the tank owner or operator.

“Ancillary equipment” means any devices including, but not limited to, such devices as piping, fittings, flanges, valves, and pumps used to distribute, meter, or control the flow of petroleum to and from an UST.

“Authorized person” means any person, including members of the Board, authorized to receive Proprietary Information. Except for members of the Board, such authorization shall be granted in writing by the Commissioner.

“Bedrock” means any rock, solid and continuous, which is exposed at the surface of the earth or overlain by unconsolidated material.

“Below ground release” means any release to the subsurface of the land or to ground water. This includes, but is not limited to, releases from the belowground portions of an underground storage tank system and belowground releases associated with overfills and transfer operations as the petroleum moves to or from an underground storage tank.

“Beneath the surface of the ground” means beneath the ground surface or otherwise covered with earthen materials.

“Board” means Tennessee Petroleum Underground Storage Tank Board established under T.C.A. §68-215-101 et seq.

“Bodily injury” means those bodily injuries caused by a release of petroleum from an UST system for which Tennessee law allows recovery.

“Borrower”, “debtor” or “obligor” is a person whose petroleum underground storage tank or UST system is encumbered by a security interest. These terms are used interchangeably.

“Cathodic protection” is a technique to prevent corrosion of a metal surface by making that surface the cathode of an electrochemical cell. For example, a tank system can be cathodically protected through the application of either galvanic anodes or impressed current.

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“Cathodic protection tester” means a person who can demonstrate an understanding of the principles and measurements of all common types of cathodic protection systems as applied to buried or submerged metal piping and tank systems. At a minimum, such persons shall have education and experience in soil resistivity, stray current, structure-to-soil potential, and component electrical isolation measurements of buried metal piping and tank systems.

“Caused” in the context of third party claims means that degree of causation required by Tennessee law to allow recovery for damages caused by a release of petroleum from an UST system.

“CERCLA” means the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended.

“Chemicals of concern” means those chemicals that have been designated as such by the Division in a chemicals of concern list. The chemicals of concern shall be chemicals that are constituents of or result from the degradation of petroleum product(s) and/or additives released from regulated petroleum underground storage tanks. The list will include those chemicals with the highest risk to human health and/or the environment. The chemicals of concern for diesel fuel will be different from the chemicals of concern for gasoline.

“Commissioner” means Commissioner of Environment and Conservation, his authorized representatives, or in the event of his absence or a vacancy in the Commissioner’s Office, the Deputy Commissioner.

“Compartmentalized tank” means an underground storage tank that consists of two or more tank compartments, which are separated from each other by a wall or bulkhead.

“Compatible” means the ability of two or more substances to maintain their respective physical and chemical properties upon contact with one another for the design life of the tank system under conditions likely to be encountered in the UST.

“Connected piping” means all underground piping including valves, elbows, joints, flanges, and flexible connectors attached to a tank system through which petroleum flows. For the purpose of determining how much piping is connected to any individual UST system, the piping that joins two UST systems should be allocated equally between them.

“Consumption” with respect to heating oil means consumed on the premises where stored.

“Containment sump” means a liquid-tight compartment that provides containment of any product releases. Containment sumps are typically used underneath product dispensers and/or for enclosing the submersible turbine pump and piping connections at the top of an underground storage tank.

“Continuous In-Tank Leak Detection System” means a release detection system that allows an underground storage tank to operate continuously or nearly continuously without interruption for release detection tests. However, the system may default to a standard or shut down test, requiring the tank to be taken briefly out of service at the end of the month if sufficient good data has not been obtained over the month. These methods include Continuous Automatic Tank Gauging Systems and Continual Reconciliation Systems.

“Controlling interest” means direct ownership of at least 50 percent of the voting stock of another entity.

RULEMAKING HEARINGS

“Corrective Action” means any activity, including but not limited to evaluation, planning, design, engineering, construction, and ancillary service, which is carried out in response to any discharge, or release of petroleum.

“Corrective Action Contractor” means a person who is carrying out any corrective action, including a person retained or hired by such person to provide services relating to a corrective action.

“Corrosion expert” means a person who, by reason of thorough knowledge of the physical sciences and the principles of engineering and mathematics acquired by a professional education and related practical experience, is qualified to engage in the practice of corrosion control on buried or submerged metal piping systems and metal tanks. Such a person shall submit documentation for review by the division that they have accreditation or certification as a corrosion specialist or senior corrosion technologist by the National Association of Corrosion Engineers or have education and a minimum of 4 years responsible charge work experience in the corrosion field. If it is determined by the division that a person has sufficient experience and education to be qualified to take responsible charge in corrosion control of buried or submerged metal piping systems and metal tanks, then that person shall be classified by the division as a Corrosion Expert for the purposes of this rule.

“Damages” in the context of third party claims means the value or cost of bodily injury or property damage caused by the release of petroleum from an UST system as determined by using methods allowed under Tennessee law.

“Date of release” means the earliest date that proof of a release exists. This will be the date a release is reported to or discovered by the division unless an earlier date is determined during the investigation of the release.

“De Minimis” means very low concentrations of petroleum.

“Department” means the Tennessee Department of Environment and Conservation.

“Dielectric material” means a material that does not conduct direct electrical current. Dielectric coatings are used to electrically isolate UST systems from the surrounding soils. Dielectric bushings are used to electrically isolate portions of the UST system (e.g., tank from piping).

“Director” means the Director of the division.

“Dispenser” means a device that discharges petroleum products from underground storage tanks into tanks in motorized vehicles, equipment tanks, or other containers, while simultaneously measuring the amount of petroleum dispensed.

“Division” means the division designated by the Commissioner of the Department of Environment and Conservation as the agency to implement the Underground Storage Tank Program in Tennessee.

“Document” means any recorded information regardless of its physical form or characteristics, including, but not limited to, written or printed material; processing cards and tapes; maps; charts; paintings; drawings; engravings; sketches; working papers and notes; reproductions of such things by any means or process; and sound, voice, or electronic recordings in any form.

“Document Control Number” means the unique number assigned by the document control officer to any document containing Proprietary Information.

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“Document Control Officer” means the individual authorized by the Commissioner in writing to be responsible for all incoming and outgoing documents identified as containing Proprietary Information.

“Drinking water supply” means any aquifer or water source whose chemical characteristics meet the primary and secondary drinking water standards as defined under rule 1200-5-1 and provides a yield of at least one-half gallon per minute. This shall also include any water supply used for drinking by the citizens of the state.

“Electrical equipment” means underground equipment that contains dielectric fluid that is necessary for the operation of equipment such as transformers and buried electrical cable.

“Eligible owner” means an owner or operator that is in “Substantial Compliance”.

“Engineering control” means a modification to a site to reduce or eliminate the potential for migration of, and exposure to, chemicals of concern. An engineering control can be used to eliminate a pathway to reduce future risk. Engineering controls may include, but are not limited to: physical or hydraulic control measures, caps, liners, point-of-use treatments, slurry walls or vapor barriers.

“Excavation zone” means the volume containing the tank system and backfill material bounded by the ground surface, walls, and floor of the pit and trenches into which the UST system is placed at the time of installation.

“Exposure pathway” means the course a chemical(s) of concern takes from a source area(s) to a receptor. Each exposure pathway includes a source area(s), a point of exposure, and an exposure route, and usually a transport/exposure medium or media.

“Farm tank” is a tank located on a tract of land devoted to the production of crops or raising animals, including fish, and associated residences and improvements. A farm tank shall be located on the farm property. “Farm” includes fish hatcheries, rangeland and nurseries with growing operations.

“Flexible piping” means piping constructed of flexible thermoplastic material that is typically installed in one continuous run with no inaccessible joints.

“Flow-through process tank” means a tank whose principle use is not for storage but is primarily used in the manufacture of a product or in a treatment process. Flow-through process tanks form an integral part of a production process through which there is a steady, variable, recurring, or intermittent flow of materials during the operation of the process. Flow-through process tanks do not include tanks used for the storage of materials prior to their introduction into the production process or for the storage of finished products or by-products from the production process.

“Foreclosure” or “foreclosure and its equivalent” means purchase at a foreclosure sale, acquisition or assignment of title in lieu of foreclosure, termination of a lease or other repossession, acquisition of right to title or possession, an agreement in satisfaction of the obligation, or any other formal or informal manner (whether pursuant to law under warranties, covenants, conditions, representations or promise from the borrower) by which the holder acquires title to or possession of secured property.

“Free product” refers to petroleum that is present as a nonaqueous phase liquid (that is, liquid not dissolved in water.)

“Fund” means petroleum underground storage tank fund established under T.C.A. §68-215-101 et seq. unless the context clearly indicates otherwise.

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“Gathering lines” means any pipeline, equipment, facility, or building used in the transportation of oil or gas during oil or gas production or gathering operations.

“Ground water” means water below the land surface in a zone of saturation.

“Guidance” means written guidelines and/or guidance documents provided by the Division. Such guidance is not mandatory, but provides information and instruction for achieving regulatory compliance. Other approaches to achieving regulatory compliance may be used in lieu of guidance provided by the Division, if those other approaches are proposed, in writing, by tank owners and/or operators for review and approval by the Division prior to implementation.

“Heating oil” means petroleum that is No. 1, No. 2, No. 4-light, No. 4-heavy, No. 5-light, No. 5-heavy, and No. 6 technical grades of fuel oil; other residual fuel oils (including Navy Special Fuel Oil and Bunker C); and other fuels when used as substitutes for one of these fuel oils. Heating oil is typically used in the operation of heating equipment, boilers, or furnaces.

“Holder” is a person who maintains indicia of ownership primarily to protect a security interest in a petroleum underground storage tank or UST system. A holder includes the initial holder or purchaser (such as a loan originator), any subsequent holder (such as a successor-in-interest or subsequent purchaser of the security interest on the secondary market), any subsequent assignee, transferee or purchaser from a holder, guarantor of an obligation, surety or any other person who holds ownership who acts on behalf of or for the benefit of a holder.

“Hydraulic lift tank” means a tank holding hydraulic fluid for a closed-loop mechanical system that uses compressed air or hydraulic fluid to operate lifts, elevators, and/or other similar devices.

“Impacted drinking water” means a water supply that contains chemicals of concern at levels that do or potentially may place human health at risk and that is being used for human consumption, and/or other human domestic use including, but not limited, to bathing, cooking, and dishwashing.

“Indicia of ownership” means evidence of a security interest, evidence of an interest in a security interest or evidence of an interest in real or personal property securing a loan or other obligations, including any legal or equitable title to real or personal property acquired incident to foreclosure and its equivalents. Evidence of such interests includes, but is not limited to, mortgages, deeds of trust, liens, surety bonds and guarantees of obligations, title held pursuant to a lease financing transaction in which the lessor does not select initially the leased property (herein “lease financing transaction”), and legal or equitable title obtained pursuant to foreclosure, and its equivalents. Evidence of such interests also includes assignments, pledges or other rights to or other forms of encumbrances against property that are held primarily to protect a security interest. A person is not required to hold title or a security interest in order to maintain indicia of ownership.

“Information” means knowledge which can be communicated by any means.

“Installation” is the process of constructing a UST system for operation.

“Institutional control” means a legal means of limiting exposure to chemicals of concern at a petroleum site with a confirmed release of petroleum.

“Instruction” in the context of proprietary information means fully informing individuals in writing of their responsibilities for safeguarding Proprietary Information and the security procedures they shall follow.

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“Legal defense cost” is any expense that an owner or operator or provider of financial assurance incurs in defending against claims or actions brought (1) by EPA or the Commissioner to require corrective action or to recover the costs of corrective action; (2) by or on behalf of a third party for bodily injury or property damage caused by an accidental release; or (3) by any person to enforce the terms of a financial assurance mechanism.

“Liquid trap” means sumps, well cellars, and other traps used in association with oil and gas production, gathering, and extraction operations (including gas production plants), for the purpose of collecting oil, water, and other liquids. These liquid traps may temporarily collect liquids for subsequent disposition or reinjection into a production or pipeline stream, or may collect and separate liquids from a gas stream.

“Maintenance” means the normal operational upkeep to prevent an underground storage tank system from releasing petroleum.

“Motor fuel” means petroleum or a petroleum-based substance that is motor gasoline, aviation gasoline, No. 1 or No. 2 diesel fuel, or any grade of gasohol, and is typically used in the operation of a motor engine.

“Month” means from the first day to the last day of the calendar month.

“Monthly” means at least once during a calendar month.

“Monitoring well” means a hole drilled into the earth, by boring or otherwise, constructed for the primary purpose of obtaining information on the elevation or physical, chemical, radiological or biological characteristics of the ground water and/or for the recovery of ground water for treatment.

“Noncommercial purposes”, with respect to motor fuel, means not for resale.

“Occurrence” means the discovery of environmental contamination at a specific time and date, due to the release of petroleum from petroleum underground storage tanks.

“On the premises where stored” with respect to heating oil means UST systems located on the same property where the stored heating oil is used.

“Operation” means the use, storage, filling or dispensing of petroleum contained in a petroleum underground storage tank or an underground storage tank (UST) system.

“Operational life” refers to the period beginning when installation of the tank system has commenced until the time the tank system is properly closed under rule 1200-1-15-.07.

“Operator” means any person in control of, or having responsibility for, the daily operation of the UST system.

“Overfill release” is a release that occurs when a tank is filled beyond its capacity, resulting in a discharge of the petroleum to the environment.

“Owner” means:

- (a) in the case of an UST system in use on November 8, 1984, or brought into use after that date, any person who owns an UST system used for storage, use, or dispensing of petroleum; and

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- (b) in the case of any UST system in use before November 8, 1984, but no longer in use on that date, any person who owned such UST immediately before the discontinuation of its use.

“Owner or operator,” in the context of financial responsibility, when the owner or operator are separate parties, refers to the party that is obtaining or has obtained financial assurances.

“Person” means any and all persons, including individuals, firms, partnerships, associations, public or private institutions, state and federal agencies, municipalities or political subdivisions, or officers thereof, departments, agencies or instrumentalities, or public or private corporations or officers thereof, organized or existing under the laws of this state or any other state or country.

“Petroleum” means crude oil or any fraction thereof that is liquid at standard temperature and pressure (60 degrees Fahrenheit and 14.7 pounds per square inch absolute). The term petroleum includes but is not limited to petroleum and petroleum based substances comprised of a complex blend of hydrocarbons derived from crude oil through processes of separation, conversion, upgrading, and finishing, such as motor fuels, jet fuels, distillate fuel oils, residual fuel oils, lubricants, petroleum solvents, and used oils.

“Petroleum marketing facilities” include all facilities at which petroleum is produced or refined and all facilities from which petroleum is sold or transferred to other petroleum marketers or to the public.

“Petroleum marketing firms” are all firms owning petroleum marketing facilities. Firms owning other types of facilities with USTs as well as petroleum marketing facilities are considered to be petroleum marketing firms.

“Petroleum UST system” means an underground storage tank system that contains petroleum or a mixture of petroleum with de minimis quantities of other hazardous substances. Such systems include those containing motor fuels, jet fuels, distillate fuel oils, residual fuel oils, lubricants, petroleum solvents, and used oils.

“Pipe” or “Piping” means a hollow cylinder or tubular conduit that is constructed of non-earthen materials.

“Pipeline facilities (including gathering lines)” are new and existing pipe rights-of-way and any associated equipment, facilities, or buildings.

“Primarily to protect a security interest” means that the holder’s indicia of ownership are held primarily for the purpose of securing payment or performance of an obligation, but does not include indicia of ownership held primarily for investment purposes, nor ownership indicia held primarily for purposes other than as a protection of a security interest. A holder may have other, secondary reasons for maintaining indicia of ownership, but the primary reason why ownership indicia are held shall be for protection of a security interest.

“Property damage” means those type damages to property caused by the release of petroleum from an UST system for which Tennessee law allows recovery.

“Proprietary Information” means any confidential information that relates to a trade secret, product, apparatus, process, operation, style of work, or financial information which is owned (not necessarily exclusively) by or licensed to a person and claimed by that person to be proprietary and confidential; provided that the claim is accompanied by a written statement from such person relating the reasons

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why such information should be held confidential. Such information may be submitted to the division by the owner/licensee of the trade secret, product, etc.; or by another governmental agency which has obtained the information. If submitted by the owner/licensee, the written statement accompanying the information claimed proprietary shall, at a minimum, answer the questions in parts 1 through 4 of this definition. If submitted by another governmental agency, the written statement need include only the accompanying statements/reasons obtained by that agency.

1. Will disclosure of the information be likely to substantially harm your competitive position? If so, what would the harm be, and why should it be viewed as substantial? What is the relationship between the disclosure and the harm?
2. What measures have you taken to guard against undesired disclosure of the information to others?
3. To what extent has the information been disclosed to others, and what precautions have you taken in connection with that disclosure?
4. Has the U.S. Environmental Protection Agency or any other Federal or State of Tennessee agency made a pertinent confidentiality determination? (If so, please include a copy of this determination, if available.)

“Provider of financial assurance” means an entity that provides financial assurance to an owner or operator of an underground storage tank through a mechanism or mechanisms allowed by rule 1200-1-15-.08(3), including a guarantor, insurer, risk retention group, surety, issuer of a letter of credit, or the state of Tennessee.

“Reasonable cost” means that monetary amount or range, as determined by the division, to be commensurate with a corrective action. The division’s determination is based on an evaluation of typical costs expected for the particular corrective action under review considering the scope and complexity of the activities involved and/or hourly rates which are competitive among approved corrective action contractors.

“Receptor” means a person, structure, surface water body, or drinking water supply that receives or may potentially receive exposure to a chemical of concern as the result of a petroleum release.

“Release” means any spilling, overfilling, leaking, emitting, discharging, escaping, leaching or disposing of a petroleum substance from an UST including its associated piping, into groundwater, surface water, or subsurface soils.

“Release detection” means determining whether a release of petroleum has occurred from the UST system into the environment or into the interstitial space between the UST system and its secondary barrier immediately around or beneath it.

“Repair” means to restore a tank or UST system component that has caused a release of petroleum from the UST system.

“Residential tank” is a tank located on property used primarily for dwelling purposes.

“Risk Based Cleanup Level” means the concentration of a chemical(s) of concern in soils or groundwater in the source area(s) that will assure an acceptable risk at the point of exposure, based upon conservative non-site-specific assumptions and default parameters.

“Routinely contains petroleum” means those parts of the UST system designed to store, transport or dispense petroleum.

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“SARA” means the Superfund Amendments and Reauthorization Act of 1986.

“Secondary containment” means a system designed and installed so that any material that is released from the primary containment is prevented from reaching the soil or groundwater outside the system.

“Security interest” means an interest in a petroleum underground storage tank or UST system or petroleum site which is created or established for the purpose of securing a loan or other obligation. Security interests include, but are not limited to, mortgages, deeds of trust, liens and title pursuant to lease financing transaction. Security interests may also arise from transactions such as sale and leasebacks, conditional sales, installment sales, trust receipt transactions, certain assignments, factoring agreements, accounts receivable financing arrangements, inventory and/or other personal property financing arrangements and consignments, if the transaction creates or establishes an interest in a petroleum underground storage tank or UST system or petroleum site for the purpose of securing a loan or other obligation.

“Septic tank” is a watertight covered receptacle designed to receive or process, through liquid separation or biological digestion, the sewage discharged from a building sewer. The effluent from such receptacle is distributed for disposal through the soil and settled solids and scum from the tank are pumped out periodically and hauled to a treatment facility.

“Site Specific Cleanup Level” means the concentration of a chemical(s) of concern in soils or groundwater in the source area(s) that will assure an acceptable risk at the point of exposure, based upon site specific conditions.

“Source” means the source of contamination. Sources may include, but are not limited to, a leaking tank, a leaking underground storage tank system, a spill, an overfill, free product or residual contaminated soil or ground water.

“Storm-water or wastewater collection system” means piping, pumps, conduits, and any other equipment necessary to collect and transport the flow of surface water run-off resulting from precipitation, or domestic, commercial, or industrial wastewater to and from retention areas or any areas where treatment is designated to occur. The collection of storm water and wastewater does not include treatment except where incidental to conveyance.

“Surface impoundment” is a natural topographic depression, man-made excavation, or diked area formed primarily of earthen materials (although it may be lined with man-made materials) that is not an injection well.

“Submersible Turbine Pump” or “STP” means pump located inside a petroleum underground storage tank, positioned near the bottom of the tank, thereby “submerged” in the petroleum.

“Tank” is a stationary device designed to contain an accumulation of petroleum and constructed of non-earthen materials (e.g., wood, concrete, steel, fiberglass) that provide structural support.

“Tank compartment” means a portion of a UST that is separated from other portions of that UST by one or more walls, or bulkheads, creating two (2) or more individual storage spaces within the UST.

“Secondary containment” means a system designed and installed so that any material that is released from the primary containment is prevented from reaching the soil or groundwater outside the system.

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“Third Party” means any person except: the owner or operator of an UST system from which a release of petroleum occurred; the owner of the petroleum site; any person in his or her capacity as an agent, servant or employee of such owner or operator or petroleum site owner; the division; the Department; or the Environmental Protection Agency.

“Third Party Claim” means any civil action brought or asserted by third party against any owner or operator for damages resulting in bodily injury or property damages which are caused by a release of petroleum from an UST system.

“Underground area” means an underground room, such as a basement, cellar, shaft or vault, providing enough space for physical inspection of the exterior of the tank situated on or above the surface of the floor.

“Underground release” means any below ground release.

“Underground storage tank” or “UST” means any one or combination of tanks (including underground pipes connected thereto) that is used to contain an accumulation of petroleum, and the volume of which (including the volume of underground pipes connected thereto) is ten percent (10%) or more beneath the surface of the ground. This term does not include any:

1. Farm or residential tank of 1,100 gallons or less capacity used for storing motor fuel for non-commercial purposes;
2. Tank used for storing heating oil for consumption on the premises where stored;
3. Septic tank;
4. Pipeline facility (including gathering lines) regulated under:
 - (i) The Natural Gas Pipeline Safety Act of 1968 (49 U.S.C. App. 1671, et seq.), or
 - (ii) The Hazardous Liquid Pipeline Safety Act of 1979 (49 U.S.C. App. 2001, et seq.), or
 - (iii) Which is an intrastate pipeline facility regulated under state laws comparable to the provisions of the law referred to in subparts 4 (i) or (ii) of this definition;
5. Surface impoundment, pit, pond, or lagoon;
6. Storm-water or wastewater collection system;
7. Flow-through process tank;
8. Liquid trap or associated gathering lines directly related to oil or gas production and gathering operations;
9. Storage tank situated in an underground area (such as a basement, cellar, mineworking, drift, shaft, or tunnel) if the storage tank is situated upon or above the surface of the floor.

The term “underground storage tank” or “UST” does not include any pipes connected to any tank which is described in 1 through 9 of this definition.

“Upgrade” means the addition or retrofit of some systems such as cathodic protection, lining, or spill and overfill controls to improve the ability of an underground storage tank system to prevent the release of petroleum.

“UST system” or “Tank system” means an underground storage tank, connected underground piping, underground ancillary equipment, and containment system, if any.

“Wastewater treatment tank” means a tank that is designed to receive and treat an influent wastewater through physical, chemical, or biological methods.

“Waters” means any and all water, public or private, on or beneath the surface of the ground, which are contained within, flow through or border upon Tennessee or any portion thereof except those

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bodies of water confined to, and retained within, the limits of private property in single ownership which do not combine or effect a junction with natural surface or underground waters.

“Week” means any seven day period, provided that days run consecutively.

“Weekly”, in the context of manual tank gauging, means once per week, resulting in a minimum of four weekly tests per month.

(5) Proprietary Information

(a) General

1. Purpose, Scope and Applicability. Any information which is supplied to the division as required or necessitated by the Tennessee Petroleum Underground Storage Tank Act or the regulations promulgated pursuant thereto or which is supplied by other governmental agencies and which is designated proprietary information (as defined in paragraph (4) of this rule) shall be handled by the division as specified in this paragraph to assure that its confidentiality is maintained. Unless it is claimed or designated as proprietary at the time it is first delivered to the division together with the supporting information required by paragraph (4) of this rule, any claim that it is proprietary is waived and any information supplied to the division under or relating to these rules shall be available for public review at any time during the State’s normal business hours, subject to availability and scheduling limitations set by the division, without further notice to any person supplying the information or having an interest in the information.
2. Policy. Division employees are prohibited from disclosing, in any manner and to any extent not authorized by law or regulations, any Proprietary Information coming to them in the course of their employment or official duties. Proprietary Information is to be held in confidence, protected in accordance with the procedures described in this paragraph, and released to authorized persons.

(b) Responsibilities

1. Commissioner. The Commissioner is responsible for:
 - (i) Designating a document control officer;
 - (ii) Assuring that all division employees receiving and handling Proprietary Information receive instruction as to their responsibility for controlling Proprietary Information;
 - (iii) Maintaining a record which lists all employees who have authorized access to Proprietary Information;
 - (iv) Obtaining a “Confidentiality Agreement” from all employees having access to Proprietary Information;
 - (v) Obtaining a “Confidentiality Agreement upon Transfer or Termination” from all employees having access to Proprietary Information in

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the event such employees decide to terminate employment or are transferred to a position not requiring such access;

- (vi) Assuring that the appropriate requirements for storage and use are met, including control of access to keys and combination;
- (vii) Taking appropriate disciplinary action concerning any division employees who fail to comply with the requirements of this paragraph; and
- (viii) Notifying the person submitting Proprietary Information which has been disclosed in violation of the requirements of this paragraph of such occurrence.

2. Document Control Officer. The Document Control Officer is responsible for the maintenance, control and distribution of all Proprietary Information received by the division as follows:

- (i) Logging of all Proprietary Information as received by the division, both incoming and outgoing;
- (ii) Assigning a document control number to each document received containing Proprietary Information;
- (iii) Maintaining a system which identifies employees authorized to receive Proprietary Information;
- (iv) Releasing Proprietary Information only to persons from whom the confidentiality agreements of subparts 1(iv) and (v) of this subparagraph have been obtained;
- (v) Maintaining a system to insure that any Proprietary Information transmitted to field locations is received;
- (vi) Maintaining at division offices a system for retrieval of documents that are furnished to other program offices;
- (vii) Authorizing and supervising the reproduction and destruction of Proprietary Information; and
- (viii) Assuring that recipients of Proprietary Information have proper storage capability prior to release of such documents, or, if they do not, requiring return of the released Proprietary Information the same day.

3. Employees. Employees are responsible for:

- (i) Controlling all Proprietary Information intrusted to them;
- (ii) Only discussing Proprietary Information with authorized persons;
- (iii) Never leaving the Proprietary Information unattended when not properly stored;

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- (iv) Never discussing the Proprietary Information over the telephone except upon approval of the document control officer should the Proprietary Information be needed in an emergency situation;
- (v) Storing the Proprietary Information as specified in part (c)5 of this paragraph when not in use and at the close of business;
- (vi) Not reproducing Proprietary Information documents. Additional copies shall be obtained through the document control officer; and
- (vii) Reporting immediately possible violations of these regulations to the Commissioner.

(c) Procedures

1. Receipt and Handling. The document control officer shall:

- (i) Receive all information claimed as proprietary and confidential which is submitted to the division;
- (ii) Log in all Proprietary Information received by the division;
- (iii) Assign a document control number to all Proprietary Information;
- (iv) Attach a Proprietary Information cover sheet to the document;
- (v) Release Proprietary Information only to authorized persons; and
- (vi) Review the claim and, using the written statement accompanying the information claimed proprietary, the answers to the questions in the definition of Proprietary Information in paragraph 4 of this rule and other information as may be required, determine whether to approve or deny it, in part or in whole.

2. Transmission

- (i) Proprietary Information shall be transmitted in a double envelope by Registered Mail, Return Receipt Requested. The inner envelope shall reflect the address of the recipient with the following wording on the front side of the inner envelope:

“Confidential Business – To Be Opened By Document Control Officer Only.”

The outer envelope shall reflect the normal address without the additional wording.

- (ii) All requests to the document control officer for Proprietary Information shall be in writing and signed by the requesting employee.
- (iii) Proprietary Information may be hand carried to other division facilities by authorized persons providing the dispatching document control

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officer maintains a record and obtains a receipt from the receiving document control officer. Information being hand carried shall be packaged as described in subpart (i) of this part.

- (iv) Proprietary Information within a division office shall be hand delivered only by an authorized person. At no time shall Proprietary Information be transmitted through inner office mailing channels.
- 3. Reproduction. Proprietary Information shall not be reproduced except upon approval by and under the supervision of the document control officer. Any reproduction shall be limited by a document control system and be subject to the same control requirements as for the original.
- 4. Destruction. Proprietary Information shall not be destroyed except upon approval by and under the supervision of the document control officer. The document control officer shall keep a record of destruction in the appropriate log and notify the person submitting the Proprietary Information.
- 5. Storage
 - (i) Documents containing Proprietary Information shall be stored within a locked cabinet so as to limit access to authorized persons.
 - (ii) Keys and/or combinations to cabinets and/or rooms where the data is stored shall be issued only to an authorized person.
- (d) Transmittal Outside Division Offices. Proprietary Information shall not be transmitted outside division offices without the approval of the Commissioner and such information shall be transmitted by the document control officer in accordance with part (c)2 of this paragraph. The person submitting the Proprietary Information shall be notified when such occurs.
- (e) Release to EPA. Notwithstanding any requirement of this paragraph seemingly to the contrary, Proprietary Information may be released to the U.S. Environmental Protection Agency in connection with the Commissioner's or Board's implementation or his or its responsibilities pursuant to the Act or as necessary to comply with federal law. Any such release of Proprietary Information to EPA, however, may be made with a confidentiality claim and shall be accompanied by the written statement received by the division pursuant to the definition of Proprietary Information as set forth in paragraph 4 of this rule. Any transmittal of Proprietary Information to EPA shall be subject to the requirements of subparagraph (d) of this paragraph. The Commissioner shall notify the submitter of Proprietary Information of the release of such information to EPA as soon as practicable, to be no later than five (5) days after such release, following receipt of EPA's request for the information.

Rule 1200-1-15-.02 UST Systems: Design, Construction, Installation and Notification is amended by deleting it in its entirety and replacing it with the following:

1200-1-15-.02 UST SYSTEMS: INSTALLATION AND OPERATION

- (1) Installation.

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- (a) At least fifteen (15) days prior to the installation of any tank and/or new UST system construction activities at the site, the tank owner shall notify the division in the following manner:
 - 1. Submit a pre-installation site sketch for all the petroleum underground storage tanks and/or UST systems for which installation and/or construction is planned in accordance with rule 1200-1-15-.03(1)(a)1; and
 - 2. Submit annual tank fees for all tanks, tank compartments and/or UST systems, which are shown on the pre-installation site sketch, in accordance with rule 1200-1-15-.10(3).
- (b) Installation shall not commence until such time as an underground storage tank certificate has been issued to the tank owner by the division.
- (c) All tanks and piping shall be installed in accordance with the manufacturer's installation instructions.
- (d) The following requirements take effect when product is being placed into a tank, tank compartment and/or UST system either during or following installation:
 - 1. Prior to placing product into the tank, tank compartment and/or UST system, spill and overfill prevention measures shall be implemented in accordance with paragraph (2) of this rule.
 - 2. Prior to placing product into the tank or tank compartment an air pressure test or a vacuum test shall be conducted in accordance with the manufacturer's recommendations. The results of this test shall be maintained for the operational life of the underground storage tank system. The test results shall contain at a minimum the following information:
 - (i) The name of the manufacturer whose pressure test recommendations have been applied to the tank;
 - (ii) The name of the person performing the test and the name of the company that person represents;
 - (iii) The date of the pressure test;
 - (iv) The identification number assigned to the facility by the division;
 - (v) The amount of pressure applied to the tank;
 - (vi) The duration of the test period; and
 - (vii) The results of the test.
 - 3. Begin release detection in accordance with rule 1200-1-15-.04 immediately if the tank or tank compartment contains more than 2.5 centimeters (one inch) of product.

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4. Immediately protect against corrosion in accordance with paragraph (3) of this rule.
 5. A line tightness test in accordance with rule 1200-1-15-.04(4)(b) and a tank tightness test in accordance with rule 1200-1-15-.04(3)(c) shall be performed upon completion of the installation and prior to the dispensing of fuel from the UST system. The results of this tightness test shall be maintained for the operational life of the underground storage tank system. Such records shall be transferred in accordance with rule 1200-1-15-.03(2)(d) at the time of ownership transfer.
- (e) Installation shall be certified in accordance with rule 1200-1-15-.03(1)(d)1 within fifteen (15) days following completion of the installation.
- (2) Spill and overfill prevention
- (a) Equipment.
1. Except as provided in part 2 of this subparagraph, to prevent spilling and overfilling associated with petroleum transfer to the UST system, owners and/or operators shall use the following spill and overfill prevention equipment:
 - (i) Spill prevention equipment that will prevent release of petroleum to the environment when the transfer hose is detached from the fill pipe (for example, a spill catchment basin); and
 - (ii) Overfill prevention equipment that will:
 - (I) Automatically shut off flow into the tank when the tank is no more than ninety-five percent (95%) full; or
 - (II) Alert the transfer operator when the tank is no more than ninety percent (90%) full by restricting the flow into the tank or triggering a high-level alarm; or
 - (III) Restrict flow thirty (30) minutes prior to overfilling, alert the operator with a high level alarm one (1) minute before overfilling, or automatically shut off flow into the tanks so that none of the fittings located on top of the tank are exposed to product due to overfilling.
 2. Owners and/or operators are not required to use the spill and overfill prevention equipment specified in part 1 of this subparagraph if:
 - (i) Alternative equipment is used that is determined by the division to be no less protective of human health and the environment than the equipment specified in subpart 1(i) or (ii) of this subparagraph; or

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- (ii) The UST system is filled by transfers of no more than twenty-five (25) gallons at one time.
- (b) Operating requirements.
 - 1. For as long as the UST system is used to store petroleum owners and/or operators shall ensure that releases due to spilling or overfilling do not occur. The owner and/or operator shall ensure that the volume available in the tank is greater than the volume of petroleum to be transferred to the tank before the transfer is made and that the transfer operation is monitored constantly to prevent overfilling and spilling.
 - 2. Owners and/operators shall keep spill catchment basins free of water, dirt, debris and/or other substances that could interfere with the ability of the catchment basin to prevent spills.
 - 3. Spill catchment basins shall be visually inspected by the owner and/or operator at least once per month to assure the integrity of the storage space provided for spill containment. A log of these inspections showing at a minimum the last twelve (12) months shall be maintained by the owner and/or operator.
 - 4. The owner and/or operator shall report, investigate, and clean up any spills and overfills in accordance with rule 1200-1-15-.05(4).
- (3) Corrosion Protection.
 - (a) Tank construction. Each tank shall be properly designed and constructed and/or properly upgraded. Any portion underground that routinely contains petroleum shall utilize one of the following methods of corrosion protection:
 - 1. The tank is constructed of fiberglass-reinforced plastic.
 - 2. The tank is constructed of steel which is cathodically protected in the following manner:
 - (i) The tank is coated with a suitable dielectric material unless cathodic protection has been added to the tank for the purpose of upgrading;
 - (ii) Field-installed cathodic protection systems are designed by a corrosion expert;
 - (iii) Impressed current systems are designed to allow determination of current operating status as required in part (c)4 of this paragraph;
 - (iv) Cathodic protection systems are operated and maintained in accordance with subparagraph (c) of this paragraph or in a manner determined by the division to provide equivalent protection against corrosion, provided that such determination is made by the division prior to installation and/or operation; and

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- (v) If cathodic protection was initially installed for the purpose of upgrading subsequent to UST system installation, the integrity of the tank has been ensured using one of the following methods:
 - (I) Internal inspection and assessment ensured that the tank was structurally sound and free of corrosion holes prior to installing the cathodic protection system.
 - (II) At the time of installation of the cathodic protection system, the tank had been installed for less than ten (10) years and monthly monitoring was being conducted in accordance with rule 1200-1-15-.04(3)(d) through (h).
 - (III) The tank was assessed for corrosion holes by conducting two (2) tightness tests that meet the requirements of rule 1200-1-15-.04(3)(c):
 - I. The first tightness test shall be conducted no more than one hundred twenty (120) days prior to installing the cathodic protection system.
 - II. The second tightness test shall be conducted between three (3) and six (6) months following the first operation of the cathodic protection system.
 - (IV) The tank was assessed for corrosion holes by a method determined by the division, prior to assessment, to be no less protective of human health and the environment than items (I) through (III) of this subpart.
- 3. The tank, which is constructed of steel and was installed on or before December 22, 1988, was lined subsequent to installation of the tank and has satisfied the following requirements:
 - (i) The lining was installed in accordance with at least the following procedures and practices:
 - (I) The lining was installed so as to effectively prevent releases for the operational life of the tank.
 - (II) The lining material is compatible with the product to be stored;
 - (III) The tank shell shall have been structurally sound prior to lining;
 - (IV) Lining manufacturers directions were followed during installation of lining;
 - (V) After the tank was lined and before the tank was returned to service, the tank shall be tank tightness tested according to rule 1200-1-15-.04(3)(c); and

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- (VI) Records that demonstrate compliance with this part shall be maintained for the remaining operational life of the tank. Such records shall be transferred in accordance with rule 1200-1-15-.03(2)(d) at the time of ownership transfer; and
 - (ii) Within ten (10) years after lining, and every five (5) years thereafter, the lined tank is/was internally inspected and found to be structurally sound with the lining still performing in accordance with original design specifications. However, tanks which use lining in combination with cathodic protection systems operated in accordance with subparagraph (c) of this paragraph do not have to be internally inspected subsequent to addition of cathodic protection.
 - (iii) Lining may be used in combination with cathodic protection if the cathodic protection system meets the requirements of subparts 2(ii) through (v) of this subparagraph.
- 4. The tank is constructed of a steel-fiberglass-reinforced-plastic composite.
- 5. The tank is constructed of metal without additional corrosion protection measures provided that:
 - (i) The tank is installed at a site that is determined by a corrosion expert not to be corrosive enough to cause it to have a release due to corrosion during its operational life; and
 - (ii) Owners and/or operators maintain records that demonstrate compliance with the requirements of subpart (i) of this part for the remaining operational life of the tank. Such records shall be transferred in accordance with rule 1200-1-15-.03(2)(d) at the time of ownership transfer.
- 6. The tank construction and corrosion protection are determined by the division to be designed to prevent the release or threatened release of any stored petroleum in a manner that is no less protective of human health and the environment than parts 1 through 5 of this subparagraph.
- (b) Piping construction. Piping that routinely contains petroleum and is in contact with the ground shall be properly designed and constructed and/or properly upgraded. Piping shall also utilize at least one of the following methods of corrosion protection:
 - 1. The piping, whether rigid or flexible in design, is constructed of nonmetallic materials such as fiberglass-reinforced plastic.
 - 2. The piping, whether rigid or flexible in design, is constructed of steel and cathodically protected in the following manner:
 - (i) The piping is coated with a suitable dielectric material unless cathodic protection was added for the purpose of upgrading;

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- (ii) Field-installed cathodic protection systems are designed by a corrosion expert;
 - (iii) Impressed current systems are designed to allow determination of current operating status as required in part (c)4 of this paragraph; and
 - (iv) Cathodic protection systems are operated and maintained in accordance with subparagraph (c) of this paragraph or in a manner determined by the division to provide equivalent protection against corrosion, provided that such determination is made by the division prior to installation and/or operation of the cathodic protection system.
 - 3. The piping is constructed of metal without additional corrosion protection measures provided that:
 - (i) The piping is installed at a site that is determined by a corrosion expert to not be corrosive enough to cause it to have a release due to corrosion during its operational life; and
 - (ii) Owners and/or operators maintain records that demonstrate compliance with the requirements of subpart (i) of this part for the remaining operational life of the piping. Such records shall be transferred in accordance with rule 1200-1-15-.03(2)(d) at the time of ownership transfer.
 - 4. The piping construction and corrosion protection are determined by the division to be designed to prevent the release or threatened release of any stored petroleum in a manner that is no less protective of human health and the environment than the requirements in parts 1 through 3 of this subparagraph.
 - 5. Fill piping used for introducing petroleum into an underground storage tank system shall not be required to have cathodic protection if it is lined with a drop tube.
- (c) Operation and maintenance of corrosion protection.

All owners and/or operators of steel UST systems with corrosion protection shall comply with the following requirements to ensure that releases due to corrosion are prevented for as long as the UST system is used to store petroleum:

- 1. All corrosion protection systems shall be operated and maintained to continuously provide corrosion protection to the metal components of that portion of the tank, piping and underground ancillary equipment that routinely contains petroleum and is in contact with the ground.
- 2. All UST systems equipped with cathodic protection systems shall be inspected for proper operation by a qualified cathodic protection tester in accordance with the following requirements:

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- (i) Frequency. All cathodic protection systems shall be tested within six (6) months of installation and at least every three (3) years thereafter;
 - (ii) The cathodic protection system shall be functioning as designed and is effectively preventing corrosion; and
 - (iii) The owner and/or operator shall maintain records that demonstrate compliance with this subparagraph.
- 3. All UST systems to which sacrificial anodes have been added for the purpose of replacing or enhancing an existing cathodic protection system shall be tightness tested in accordance with subparagraphs (3)(c) and (4)(b) of rule 1200-1-15-.04. The tightness test shall be conducted no later than six (6) months, but no sooner than three (3) months, following the addition of the anodes.
- 4. UST systems with impressed current cathodic protection systems shall also be inspected every sixty (60) days to ensure the equipment is running properly. The results of the inspection shall be recorded in a format established by the division and in accordance with the instructions provided by the division.
- 5. For UST systems using cathodic protection, records of the operation of the cathodic protection shall be maintained, in accordance with rule 1200-1-15-.03(2), to demonstrate compliance with the performance standards in this paragraph. These records shall be maintained in accordance with the following:
 - (i) The results of testing from the last two inspections required in part 2 of this subparagraph shall be retained;
 - (ii) A record of the addition of sacrificial anodes to an existing cathodic protection system shall be retained for the remaining operational life of the underground storage tank system and such records shall be transferred in accordance with rule 1200-1-15-.03(2)(d) at the time of ownership transfer;
 - (iii) The results of tightness testing required in part 3 of this subparagraph shall be retained for the remaining operational life of the underground storage tank system. Such records shall be transferred in accordance with rule 1200-1-15-.03(2)(d) at the time of ownership transfer; and
 - (iv) The results of the last three inspections required in part 4 of this subparagraph shall be retained.
- (4) Compatibility.

Owners and/or operators shall use an UST system made of or lined with materials that are compatible with the petroleum stored in the UST system.
- (5) Repairs allowed.

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Owners and/or operators of UST systems shall ensure that repairs will prevent releases due to structural failure or corrosion as long as the UST system is used to store petroleum. The repairs shall meet the following requirements:

- (a) Repairs to UST systems shall be conducted so as to effectively prevent releases for the operational life of the tank system.
- (b) Repairs to fiberglass-reinforced plastic tanks shall be made by the manufacturer's authorized representatives or in accordance with the manufacturer's specifications.
- (c) Metal pipe sections and fittings that have released product as a result of corrosion or other damage shall be replaced. Fiberglass pipes and fittings may be repaired in accordance with the manufacturer's specifications.
- (d) Repaired tanks and/or piping shall be tightness tested in accordance with subparagraphs (3)(c) and (4)(b) of rule 1200-1-15-.04 within thirty (30) days following the date of the completion of the repair except as provided in parts 1 through 3 of this subparagraph:
 - 1. The repaired tank is internally inspected prior to placing product in the tank ; or
 - 2. The repaired portion of the UST system is monitored monthly for releases in accordance with a method specified in rule 1200-1-15-.04(3)(d) through (h); or
 - 3. Another test method is used, provided that prior to use in the State of Tennessee that method is determined by the division to be no less protective of human health and the environment than those listed above.
- (e) Within six (6) months following the repair of any cathodically protected UST system, the cathodic protection system shall be tested in accordance with parts (3)(c)2 and 3 of this rule to ensure that it is operating properly.
- (f) UST system owners and/or operators shall maintain records of each repair that demonstrate compliance with the requirements of this paragraph for the remaining operating life of the UST system. Such records shall be transferred in accordance with rule 1200-1-15-.03(2)(d) at the time of ownership transfer.

Rule 1200-1-15-.03 General Operating Requirements is amended by deleting it in its entirety and replacing it with the following:

1200-1-15-.03 NOTIFICATION, REPORTING AND RECORD KEEPING.

- (1) Notification requirements.
 - (a) Any owner who brings a new underground storage tank system into use shall notify the division as follows:
 - 1. Pre-installation site sketch.

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Notification shall be made fifteen (15) days prior to commencement of installation of such underground storage tank systems by submitting a pre-installation site sketch to the division. The pre-installation site sketch shall include, but not be limited to the following information: the property address; the business name; the tank owner's name and address; street names; property lines; the number of compartments in each tank; the location of the underground storage tanks and the associated underground piping on the property; the location of utilities including electrical wiring for the dispensers, pumps, cathodic protection systems, release detection systems, etc.; buildings on the property; and an arrow indicating the direction of north. This information shall be submitted in a format established by the division and the pre-installation site sketch shall be completed in accordance with instructions provided by the division.

2. Notification form for newly installed tanks.

The owner of a newly installed tank shall submit notification of the underground storage tank system installation to the division within fifteen (15) days in accordance with subparagraphs (b) through (d) of this paragraph. The owner shall use the notification form designated by the division.

[Note: Owners and/or operators of UST systems that were in the ground on or after May 8, 1986, unless taken out of operation on or before January 1, 1974, were required to notify the designated state or local agency in accordance with the Hazardous and Solid Waste Amendments of 1984, Public Law 98-616, on a form published by EPA on November 8, 1985, (50 FR 46602) unless notice was given pursuant to section 103(c) of CERCLA. Owners and/or operators who have not complied with the notification requirements may use the notification form designated by the division.]

- (b) Owners and/or operators shall complete the notification form accurately and in its entirety for each tank, tank compartment, and the piping connected thereto, for which notice is required in accordance with part (a)2 of this paragraph. The form shall be completed in accordance with the instructions provided by the division.
- (c) Owners required to submit notification under part (a)2 of this paragraph shall provide notification to the division for each tank, and tank compartment, they own. Owners may provide notification for several tanks using one notification form, but owners who own tanks located at more than one place of operation shall file a separate notification form for each separate place of operation.
- (d) All owners and operators of UST systems installed after December 22, 1988 shall certify in the notification form compliance with the following requirements:
 - 1. Installation of tanks and piping has been certified using one of the following methods:
 - (i) The installer has been certified by the tank and piping manufacturers; or
 - (ii) The installation has been inspected and certified by a registered professional engineer with education and experience in UST system installation; or

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- (iii) The installation has been inspected and approved by the division; or
 - (iv) All work listed in the manufacturer's installation checklist has been completed; or
 - (v) The owner and operator have complied with another method for ensuring compliance with rule 1200-1-15-.02(1) that has been determined by the division prior to installation to be no less protective of human health and the environment.
 - 2. Cathodic protection of steel tanks and piping under rule 1200-1-15-.02(3)(a) and (b);
 - 3. Financial responsibility under rule 1200-1-15-.08; and
 - 4. Release detection under rule 1200-1-15-.04(2).
- (e) All owners and operators of UST systems installed after December 22, 1988 shall ensure that the installer certifies in the notification form that the methods used to install the tanks and piping complies with the requirements in rule 1200-1-15-.02(1).
- (f) Any person who sells a tank intended to be used as an underground storage tank shall notify the purchaser at the time of sale of such tank of the owner's obligations for notification prior to installation under subparagraph (a) of this paragraph. The seller shall place the statement contained in Appendix 1200-1-15-.03-A on all invoices and shipping tickets.
- (g) Any change in the status of the tanks at a petroleum UST facility shall be reported within thirty (30) days of said change. This includes but is not limited to changes of ownership, upgrading or replacement of tanks, changes in mailing address, permanent closure of a tank compartment, and changes in service. Such reports shall be made using an amended notification form. In the case of a sale of tanks, the seller shall submit the notification form designated by the division, completed in accordance with instructions provided by the division, and shall also inform the buyer of the notification requirement.
- (2) Reporting and Record Keeping.
- Owners and/or operators of UST systems shall cooperate fully with inspections, monitoring and testing conducted by the division, as well as requests for document submission, testing, and monitoring by the owner or operator in accordance with the Tennessee Petroleum Underground Storage Tank Act T.C.A. §68-215-107.
- (a) Reporting. Owners and/or operators shall submit the following information to the division:
- 1. Notification for all UST systems (rule 1200-1-15-.03(1), which includes certification of installation for new UST systems (rule 1200-1-15-.03(1)(d) and (e));

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2. Reports of all releases including suspected releases (rule 1200-1-15-.05(1)), spills and overfills (rule 1200-1-15-.05(4)), and confirmed releases (rule 1200-1-15-.06);
 3. Corrective actions planned or taken including, but not limited to, initial response measures (rule 1200-1-15-.06(3)), hazard management measures (rule 1200-1-15-.06(4)), initial site characterization and exposure assessment (rule 1200-1-15-.06(5)), corrective action plan (rule 1200-1-15-.06(10)), and as otherwise directed by the division;-
 4. A notification before permanent closure or change-in-service (rule 1200-1-15-.07(3) and (4)); and
 5. Tank closure activities including site assessment results (rule 1200-1-15-.07(5)).
- (b) Record Keeping. Owners and/or operators shall maintain the following information:
1. A corrosion expert's analysis of site corrosion potential if corrosion protection equipment is not used (rule 1200-1-15-.02(3)(a)5; rule 1200-1-15-.02(3)(b)3);
 2. Documentation of operation of corrosion protection equipment (rule 1200-1-15-.02(3)(c));
 3. Documentation of UST system repairs (rule 1200-1-15-.02(5)(f));
 4. Recent compliance with release detection requirements (rule 1200-1-15-.04(5)); and
 5. Results of the site investigation conducted at permanent closure (rule 1200-1-15-.07(5)).
- (c) Availability and Maintenance of Records.
1. Owners and/or operators shall keep the records required either:
 - (i) At the UST site and immediately available for inspection by the division; or
 - (ii) At a readily available alternative site and be provided for inspection to the division upon request; or
 - (iii) In the case of permanent closure records required under rule 1200-1-15-.07(6), owners and/or operators are also provided with the additional alternative of mailing closure records to the division if they cannot be kept at the site or an alternative site as indicated in parts 1 or 2 of this subparagraph.
 2. If an inspection is scheduled by the division in advance of the date of that inspection, all records shall be present and available for review during the scheduled inspection.

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- (d) **Records Transfer.** Upon transfer of ownership, including, but not limited to, sale of the UST systems, originals and/or copies of all documents required to satisfy the reporting and recordkeeping requirements of this paragraph shall be transferred to the new owner of the USTs at the time of ownership transfer.

APPENDIX 1200-1-15-.03-A

Statement for Shipping Tickets and Invoices

Note: A Federal law (the Resource Conservation and Recovery Act (RCRA), as amended (Pub. L. 98-616)) requires owners of certain underground storage tanks to notify designated state or local agencies by May 8, 1986, of the existence of their tanks. The Tennessee Petroleum Underground Storage Tanks Act (T.C.A. §68-215-101 et seq.) also contains notification requirements. Notifications for tanks brought into use after July 1, 1989 shall be made fifteen (15) days in advance of installation. Consult EPA's regulations, issued on November 8, 1985 (40 CFR Part 280), state law (T.C.A. §68-215-101 et seq.) and state regulations (Chapter 1200-1-15) to determine if you are affected by these laws and regulations.

Rule 1200-1-15-.04 Release Detection is amended by deleting it in its entirety and replacing it with the following:

1200-1-15-.04 RELEASE DETECTION.

- (1) **General requirements for release detection.**
 - (a) Owners and/or operators of UST systems shall provide a method, or combination of methods, of release detection that:
 - 1. Can detect a release from any portion of the tank and the connected underground piping that routinely contains petroleum;
 - 2. Is installed, calibrated, operated, and maintained in accordance with the manufacturer's instructions, including routine maintenance and service checks for operability or running condition; and
 - 3. Meets the performance requirements of paragraph (3) or (4) of this rule, with any performance claims and their manner of determination described in writing by the equipment manufacturer or installer. In addition, methods used after December 22, 1990 except for methods permanently installed prior to that date, shall be capable of detecting the leak rate or quantity specified for that method in subparagraphs (3)(b), (c), and (d) or (4)(a) and (b) of this rule with a probability of detection of 0.95 and a probability of false alarm of 0.05.
 - (b) When a release detection method operated in accordance with the performance standards in paragraphs (3) and (4) of this rule indicates a release may have occurred, owners and operators shall notify the division in accordance with rule 1200-1-15-.05. If more than one method of release detection is operated on a UST system, a suspected release shall be reported to the division in accordance with rule 1200-1-15-.05 if any one of the release detection methods indicates a release may have occurred.

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- (c) Owners and/or operators of newly installed USTs shall comply with the release detection requirements of this rule immediately upon installation.
 - (d) If a method of release detection that complies with the requirements of this rule cannot be applied to and/or operated for any UST system, the owner and/or operator of that UST system shall complete the closure procedures in rule 1200-1-15-.07.
 - (e) If a release detection method selected by the owner and/or operator cannot meet the performance standards in paragraph (3) and (4) of this rule to the satisfaction of the division, then the owner and/or operator shall select another method of release detection.
 - (f) The dispenser shall be accessed and inspected for petroleum releases at least monthly. A log of these inspections showing at a minimum the last twelve (12) months shall be maintained by the owner and/or operator.
- (2) Requirements for petroleum UST systems.

Owners and operators of petroleum UST systems shall provide release detection for tanks and piping as follows:

- (a) Tanks. Tanks shall be monitored at least monthly for releases using one of the methods listed in subparagraphs (3)(d) through (i) of this rule, except that:
 - 1. UST systems that meet the performance standards in rule 1200-1-15-.02, and the monthly inventory control requirements in subparagraphs (3)(a) or (b) of this rule, may use tank tightness testing (conducted in accordance with subparagraph (3)(c) of this rule) at least every five (5) years until ten (10) years after the tank was installed or upgraded in compliance with the performance standards in rule 1200-1-15-.02. However, tanks which were over ten (10) years old when the cathodic protection system was added in accordance with rule 1200-1-15-.02 (1)(a)2.(v)(III) shall use a monthly monitoring method of release detection in accordance with subparagraphs (3)(d) through (i) of this rule.
 - 2. Tanks which meet the volume, diameter and test duration requirements as set forth in part (3)(b)1(i) of this rule may use manual tank gauging (conducted in accordance with subparagraph (3)(b) of this rule).
- (b) Piping. Underground piping that routinely contains petroleum shall be monitored for releases in a manner that meets one of the following requirements:
 - 1. Pressurized piping. Underground piping that conveys petroleum under pressure shall:
 - (i) Be equipped with an automatic line leak detector conducted in accordance with subparagraph (4)(a) of this rule; and
 - (ii) Have an annual line tightness test conducted in accordance with subparagraph (4)(b) of this rule or have monthly monitoring conducted in accordance with subparagraph (4)(c) of this rule.

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2. Suction piping. Underground piping that conveys petroleum under suction shall either have a line tightness test conducted at least every three (3) years and in accordance with subparagraph (4)(b) of this rule, or use a monthly monitoring method conducted in accordance with subparagraph (4)(c) of this rule. No release detection is required for suction piping that is designed and constructed to meet the following standards:
 - (i) The below-grade piping operates at less than atmospheric pressure;
 - (ii) The below-grade piping is sloped so that the contents of the pipe will drain back into the storage tank if the suction is released;
 - (iii) Only one check valve is included in each suction line;
 - (iv) The check valve is located directly below and as close as practical to the suction pump; and
 - (v) A method is provided that allows compliance with subparts through (iv) of this part to be readily determined.

(3) Methods of release detection for tanks.

Each method of release detection for tanks used to meet the requirements of paragraph (2) of this rule shall be conducted in accordance with the following:

- (a) Inventory control. Inventory control shall meet the following requirements:
 1. Inventory volume measurements for petroleum inputs, withdrawals, and the amount still remaining in the tank are recorded each operating day;
 2. The equipment used is capable of measuring the level of petroleum over the full range of the tank's height to the nearest one-eighth of an inch;
 3. Petroleum levels are measured and recorded to an accuracy of at least the nearest one-eighth of an inch;
 4. The petroleum inputs are reconciled with delivery receipts by measurement of the tank inventory volume before and after delivery;
 5. Deliveries are made through a drop tube that extends to within one foot of the tank bottom;
 6. Measurements of the level of petroleum in the tank which are taken using a gauge stick are made through a drop tube;
 7. Petroleum dispensing is metered and recorded to within the local standards for meter calibration or an accuracy of six (6) cubic inches for every five (5) gallons of petroleum withdrawn, and the meters are calibrated annually;
 8. The measurement of any water level in the bottom of the tank is made and recorded to the nearest one-eighth of an inch at least once a month; and

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9. A release is suspected and subject to the requirements of rule 1200-1-15-.05 if the monthly total of either daily overages or shortages is greater than one percent (1.0%) of the total monthly flow-through plus one hundred thirty (130) gallons.

(b) Manual tank gauging.

1. Manual tank gauging shall only be applicable to tanks as set forth below:

- (i) Tanks which meet the volume, diameter and test duration requirements as set forth below may use manual tank gauging as the sole method of release detection:

NOMINAL CAPACITY	TANK DIAMETER	MINIMUM DURATION OF TEST
up to 550 gallons	*	36 hours
551 – 1000 gallons	64 inches	44 hours
551 – 1000 gallons	48 inches	58 hours

* Any diameter of tank up to 550 gallons may use manual tank gauging as the sole method of release detection if the duration of the test is at least 36 hours.

- (ii) Manual tank gauging shall not be used as the sole method of release detection for tanks of 551 to 1000 gallons nominal capacity which cannot meet the diameter or test duration requirements as set forth in subpart (i) of this part or for tanks of 1001 to 2000 gallon nominal capacity. These tanks shall use manual tank gauging in combination with tank tightness testing in accordance with subparagraph (2)(a) of this rule.
- (iii) Tanks of greater than 2000 gallons nominal capacity shall not use this method to meet the requirements of this rule.

2. Manual tank gauging shall meet the following requirements:

- (i) Tank liquid level measurements are taken at the beginning and ending of a period of at least thirty-six (36) hours during which no liquid is added to or removed from the tank;
- (ii) Level measurements are based on an average of two consecutive stick readings at both the beginning and ending of the required period;
- (iii) The equipment used is capable of measuring the level of petroleum over the full range of the tank's height to the nearest one-eighth of an inch;
- (iv) Petroleum levels are measured and recorded to an accuracy of at least the nearest one-eighth of an inch;

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- (v) A release is suspected and subject to the requirements of rule 1200-1-15-.05 if the variation between beginning and ending measurements exceeds the weekly or monthly standards in the following table:

NOMINAL CAPACITY	TANK DIAMETER	MINIMUM DURATION OF TEST	WEEKLY STANDARD (one test)	MONTHLY STANDARD (Average of 4 Tests)
Up to 550 gallons		36 hours	10 gallons	5 gallons
551 – 1000 gallons		36 hours	13 gallons	7 gallons
551 – 1000 gallons	64 inches	44 hours	9 gallons	4 gallons
551 – 1000 gallons	48 inches	58 hours	12 gallons	6 gallons
1001 – 2000 gallons		36 hours	26 gallons	13 gallons

(c) Tank tightness testing.

1. Tank tightness testing shall be capable of detecting a 0.1 gallon per hour leak rate from any portion of the tank that routinely contains petroleum while accounting for the effects of thermal expansion or contraction of the petroleum, vapor pockets, tank deformation, evaporation or condensation, and the location of the water table.
2. Tank tightness testing devices, automatic tank gauging devices or other equipment may be used provided that the testing meets the performance criteria set forth in part 1 of this subparagraph.
3. The information relating to the tank tightness test shall be reported in a format established by the division. The tank tightness test report shall include, but is not necessarily limited to the following information:
 - (i) Information which identifies the tank and the facility;
 - (ii) Information which identifies the test method and test conditions established by the manufacturer's specifications and/or required by the third party certification of the method;
 - (iii) Information which identifies the person and/or company performing the test;
 - (iv) Data gathered during the performance of the test; and
 - (v) Results expressed as follows:
 - (I) Leak rate in gallons per hour and as "Pass" or "Fail" for volumetric test methods; or
 - (II) "Pass" or "Fail" for non-volumetric test methods.

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4. A release is suspected and subject to the requirements of rule 1200-1-15-.05 if the method detects a release rate greater than the performance standard for the method as established by the manufacturer's specifications and/or third party certification.
- (d) Automatic tank gauging. Equipment for automatic tank gauging shall be permanently installed in the tank and shall meet one of the following requirements:
1. For automatic tank gauging devices which were installed prior to December 22, 1990, and which do not meet the requirements of parts 2 or 3 of this subparagraph:
 - (i) Inventory control (or another test of equivalent performance) shall be conducted in accordance with the requirements of subparagraph (3)(a) of this rule; and
 - (ii) A release is suspected and subject to the requirements of rule 1200-1-15-.05 if the monthly total of either daily overages or shortages is greater than 1.0 percent of the total monthly flow-through plus 130 gallons.
 2. For automatic tank gauging devices capable of detecting at least a 0.2 gallon per hour leak rate from any portion of the tank that routinely contains petroleum shall meet the following requirements:
 - (i) The monitor shall be placed in the leak test mode at least once per month; and
 - (ii) A release is suspected and subject to the requirements of rule 1200-1-15-.05 if the monitoring results indicate that the underground storage tank has had a release above the established threshold of the automatic tank gauging device as determined through third party certification.
 3. For automatic tank gauging systems which are capable of continuous statistical release detection shall meet the following requirements:
 - (i) The automatic tank gauging system shall be placed in the leak test mode at least once per month if a test cannot be obtained during any one month period, except for those systems which also use Statistical Inventory Reconciliation in accordance with subparagraph (3)(h) of this rule; and
 - (ii) A release is suspected and subject to the requirements of rule 1200-1-15-.05 if the monitoring results indicate that the underground storage tank has had a release above the established threshold of the automatic tank gauging device as determined through third party certification, except that those systems also using Statistical Inventory Reconciliation shall report suspected releases in accordance with subparagraph (3)(h) of this rule.

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- (e) Vapor monitoring. Testing or monitoring for vapors within the soil gas of the excavation zone shall meet the following requirements:
1. The materials used as backfill are sufficiently porous (e.g., gravel, sand, crushed rock) to readily allow diffusion of vapors from releases into the excavation area;
 2. The stored petroleum, or a tracer compound placed in the tank system, is sufficiently volatile (e.g., gasoline) to result in a vapor level that is detectable by the monitoring devices located in the excavation zone in the event of a release from the tank;
 3. The measurement of vapors by the monitoring device is not rendered inoperative by the ground water, rainfall, or soil moisture or other known interferences so that a release could go undetected for more than thirty (30) days;
 4. The level of background contamination in the excavation zone will not interfere with the method used to detect releases from the tank;
 5. The vapor monitors are designed and operated to detect any significant increase in concentration above background of the petroleum stored in the tank system, a component or components of that substance, or a tracer compound placed in the tank system;
 6. In the UST excavation zone, the site is assessed to ensure compliance with the requirements in parts 1 through 4 of this subparagraph and to establish the number and positioning of monitoring wells that will detect releases within the excavation zone from any portion of the tank that routinely contains petroleum;
 7. Monitoring wells are clearly marked and secured to avoid unauthorized access and tampering; and
 8. A release is suspected and subject to the requirements of rule 1200-1-15-.05 if:
 - (i) An automatic and/or continuous monitoring device signals an alarm;
 - (ii) Any liquid product is observed during manual monitoring; or
 - (iii) Any significant increase in concentration above background of the petroleum stored in the tank system, a component or components of that substance or a tracer compound placed in the tank system is detected by a monitoring device.
- (f) Groundwater monitoring. Testing or monitoring for liquids on the ground water shall meet the following requirements:
1. Ground water monitoring shall not be allowed in areas where the tank excavation zone has encountered bedrock;

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2. The petroleum stored is immiscible in water and has a specific gravity of less than one;
 3. Ground water is never more than twenty (20) feet from the ground surface and the hydraulic conductivity of the soil(s) between the UST system and the monitoring wells or devices is not less than 0.01 cm/sec (e.g., the soil should consist of gravels, coarse to medium sands, coarse silts or other permeable materials);
 4. The slotted portion of the monitoring well casing shall be designed to prevent migration of natural soils or filter pack into the well and to allow entry of petroleum on the water table into the well under both high and low ground water conditions;
 5. Monitoring wells shall be sealed from the ground surface to the top of the filter pack;
 6. Monitoring wells or devices intercept the excavation zone or are as close to it as is technically feasible;
 7. The continuous monitoring devices or manual methods used can detect the presence of at least one-eighth of an inch of free product on top of the ground water in the monitoring wells;
 8. Within and immediately below the UST system excavation zone, the site is assessed to ensure compliance with the requirements in parts 1 through 6 of this subparagraph and to establish the number and positioning of monitoring wells or devices that will detect releases from any portion of the tank that routinely contains petroleum;
 9. Monitoring wells are clearly marked and secured to avoid unauthorized access and tampering; and
 10. A release is suspected and subject to the requirements of rule 1200-1-15-.05 if:
 - (i) An automatic and/or continuous monitoring device signals an alarm; or
 - (ii) Any liquid product is observed on top of the groundwater in the monitoring well during manual monitoring.
- (g) Interstitial monitoring. Interstitial monitoring between the UST system and a secondary barrier immediately around or beneath it may be used, but only if the system is designed, constructed and installed to detect a release from any portion of the tank that routinely contains petroleum and also meets one of the following requirements:
1. For double-walled UST systems, the sampling or testing method can detect a release through the inner wall in any portion of the tank that routinely contains petroleum;

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2. For UST systems with a secondary barrier within the excavation zone, the sampling or testing method used can detect a release between the UST system and the secondary barrier; provided that the following conditions are met:
 - (i) The secondary barrier around or beneath the UST system consists of artificially constructed material that is sufficiently thick and impermeable (at least 10^{-6} cm/sec for the petroleum stored) to direct a release to the monitoring point and permit its detection;
 - (ii) The barrier is compatible with the petroleum stored so that a release from the UST system will not cause a deterioration of the barrier allowing a release to pass through undetected;
 - (iii) For cathodically protected tanks, the secondary barrier shall be installed so that it does not interfere with the proper operation of the cathodic protection system;
 - (iv) The ground water, soil moisture, or rainfall will not render the testing or sampling method used inoperative so that a release could go undetected for more than thirty (30) days;
 - (v) The site is assessed to ensure that the secondary barrier is always above the ground water and not in twenty-five (25) year flood plain, unless the barrier and monitoring designs are for use under such conditions; and,
 - (vi) Monitoring wells are clearly marked and secured to avoid unauthorized access and tampering.
 3. For tanks with an internally fitted liner, an automated device can detect a release between the inner wall of the tank and the liner, and the liner is compatible with the substance stored.
- (h) Statistical inventory reconciliation. Statistical analysis of inventory, delivery and dispensing data collected over a period of time shall meet the following requirements:
1. Inventory control shall be conducted in accordance with the requirements of subparagraph (3)(a) of this rule;
 2. A report shall be generated monthly, within ten (10) days after the end of the data collection for that time period. The report shall include, but is not limited to the following:
 - (i) The inventory records used, i.e., the raw data; and
 - (ii) The statistical inventory reconciliation determination;
 3. For quantitative statistical inventory reconciliation methods, the numerical leak rate shall be reported unless the statistical inventory reconciliation determination results in an "Inconclusive" under the provisions of subpart 4(iii) of this subparagraph;

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4. The statistical inventory reconciliation determination shall be reported using the term "Pass", "Fail" or "Inconclusive". For quantitative statistical inventory reconciliation methods the applicable term shall be used in accordance with subparts (i) through (iii) of this part:
 - (i) If the calculated leak rate does not exceed 0.10 gallons per hour, the results shall be reported as a "Pass";
 - (ii) If the calculated leak rate exceeds 0.10 gallons per hour, the results shall be reported as a "Fail";
 - (iii) If the leak rate cannot be calculated using the available data, the results shall be reported as an "Inconclusive";
5. If the statistical inventory reconciliation method used requires more than one month of data for initial evaluation, another method of release detection shall be conducted during that initial data collection period;
6. If there are too few operational days for statistical inventory reconciliation to successfully analyze during any month, then another method of release detection shall be utilized during that month; and
7. The owner/operator shall report a suspected release in accordance with rule 1200-1-15-.05:
 - (i) When the statistical inventory reconciliation determination is reported as a "Fail"; or
 - (ii) When two consecutive "Inconclusive" statistical inventory reconciliation determinations are reported.
- (i) Other methods. Any other type of release detection method, or combination of methods, can be used if:
 1. It can detect a 0.2 gallon per hour leak rate or a release of 150 gallons within a month with a probability of detection of 0.95 and a probability of false alarm of 0.05; or
 2. The division may approve another method if the owner and operator can demonstrate that the method can detect a release as effectively as any of the methods allowed in subparagraphs (c) through (h) of paragraph (3) of this rule. In comparing methods, the division shall consider the size of release that the method can detect and the frequency and reliability with which it can be detected. If the method is approved, the owner and operator shall comply with any conditions imposed by the division on its use to ensure the protection of human health and the environment.
- (4) Methods of release detection for piping.

Each method of release detection for piping used to meet the requirements of paragraph (2) of this rule shall be conducted in accordance with the following:

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- (a) Automatic line leak detectors. Methods which alert the operator to the presence of a leak by restricting or shutting off the flow of petroleum through piping or triggering an audible or visual alarm may be used only if they detect leaks of three (3) gallons per hour at ten (10) pounds per square inch line pressure within one (1) hour. An annual test of the operation of the leak detector shall be conducted in accordance with the manufacturer's requirements.
 - (b) Line tightness testing. A periodic test of piping may be conducted only if it can detect a 0.1 gallon per hour leak rate at one and one-half times the operating pressure.
 - (c) Applicable tank methods. Any of the methods in subparagraphs (3)(e) through (i) of this rule may be used if they are designed to detect a release from any portion of the underground piping that routinely contains petroleum.
- (5) Release detection record keeping.

All UST system owners and/or operators shall maintain records in accordance with rule 1200-1-15-.03(2) demonstrating compliance with all applicable requirements of this rule. Release detection information shall be recorded in a format established by the division and in accordance with instructions provided by the division. These records shall include the following:

- (a) All written performance claims pertaining to any release detection system used, and the manner in which these claims have been justified or tested by the equipment manufacturer or installer, shall be maintained for five (5) years from the date of installation or until such time as the release detection method to which the performance claim pertains is no longer used at the facility, whichever is later;
- (b) The results of any sampling, testing, or monitoring shall be maintained for at least one (1) year except that the results of tank tightness testing conducted in accordance with subparagraph (3)(c) of this rule shall be retained until the next test is conducted; and
- (c) Written documentation of all calibration, maintenance, and repair of release detection equipment permanently located on-site shall be maintained for at least one year after the servicing work is completed. Any schedules of required calibration and maintenance provided by the release detection equipment manufacturer shall be retained for five (5) years from the date of installation or until such time as the release detection method to which the schedule of required calibration and maintenance pertains is no longer used at the facility, whichever is later;

Rule 1200-1-15-.05 Release Reporting, Investigation and Confirmation is amended by deleting paragraph (2) in its entirety and replacing it with the following:

- (2) Investigation due to environmental impacts.

When required by the division, owners and/or operators of UST systems shall follow the procedures in paragraph (3) of this rule to determine if the UST system is the source of environmental impacts. These impacts include the discovery of petroleum escaping from the UST system, associated containment devices, or any component of a tank, line, dispenser, meter, or line leak detector, not designed for the purpose of dispensing petroleum as well as the discovery of petroleum in the environment (such as the presence of free product or

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vapors in soils, basements, sewer and utility lines, and nearby surface and drinking waters) that has been observed by the division or brought to its attention by another party.

Rule 1200-1-15-.07 Out-of-Service UST Systems and Closure is amended by deleting it in its entirety and replacing it with the following:

1200-1-15-.07 OUT-OF-SERVICE UST SYSTEMS AND CLOSURE.

- (1) Temporary closure.
 - (a) When an UST system is temporarily closed, owners and/or operators shall continue operation and maintenance of corrosion protection in accordance with rule 1200-1-15-.02(3), and any release detection in accordance with rule 1200-1-15-.04. Rule 1200-1-15-.05 and rule 1200-1-15-.06 shall be complied with if a release is suspected or confirmed. However, release detection is not required as long as the UST system is empty. The UST system is empty when all materials have been removed using commonly employed practices so that no more than two and one-half (2.5) centimeters (one inch) of residue remains in the system.
 - (b) When an UST system is temporarily closed for three (3) months or more, owners and/or operators shall also comply with the following requirements:
 - 1. Leave vent lines open and functioning;
 - 2. Cap and secure all other lines, pumps, manways, and ancillary equipment; and
 - 3. File an amended notification form showing the tank system as Temporarily Out of Use.
- (2) Substandard UST Systems. Unless directed to do otherwise by the division owners and/or operators of an UST system which does not meet the requirements in rule 1200-1-15-.02(2) and (3) shall permanently close the substandard UST system in accordance with paragraphs (4) and (5) of this rule, except that parts (4)(a)6 and 7 of this rule shall not apply to a substandard UST system. The substandard UST system shall complete the permanent closure, including submittal of the Permanent Closure Report, within sixty (60) days of division approval of the Application for Permanent Closure of Underground Storage Tanks.
- (3) Tank compartment closure.

For a tank that has more than one (1) tank compartment, one (1) or more of the tank compartments may be permanently closed in accordance with the provisions of this paragraph as well as paragraph (5) of this rule. If all the compartments in a tank are to be permanently closed, the requirements for permanent closure set forth in paragraphs (4) and (5) of this rule shall be followed by the tank owner and/or operator.

 - (a) At least thirty (30) days before beginning tank compartment closure owners and/or operators shall apply for tank compartment closure. Application for tank compartment closure shall meet the following requirements:

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1. An Application for Closure of Tank Compartment(s) shall be submitted in a format established by the division. The application shall be completed according to the instructions provided by the division.
 2. The Application for Closure of Tank Compartment(s) shall be accompanied by a written statement provided by either the tank manufacturer or a Registered Professional Engineer certifying the following:
 - (i) The planned closure of the tank compartment(s) will not cause structural damage to the tank; and
 - (ii) The corrosion protection system will continue to function as designed and will continue to effectively prevent corrosion of the tank following completion of the planned closure of the tank compartment(s).
 3. The tank owner and/or operator or other responsible party shall obtain division approval of the Application for Closure of Tank Compartment(s) prior to closing the tank compartment(s).
 4. The application shall constitute a plan for tank compartment(s) closure.
 5. Tank compartment(s) closure activities shall be conducted in accordance with the plan contained in the approved Application for Closure of Tank Compartment(s). If alterations to the plan are required, an amended Application for Closure of Tank Compartment(s) shall be submitted to the division for approval.
 6. The approved Application for Closure of Tank Compartment(s) shall be available for inspection upon request at the petroleum site at the time of tank compartment closure.
 7. Division approval of the Application for Closure of Tank Compartment(s) shall be valid for twelve (12) months following such approval. However, such approval shall not be transferable to another person during that twelve (12) month approval time.
 8. If tank compartment(s) closure is not completed within twelve (12) months, the tank owner and/or operator shall submit a new Application for Closure of Tank Compartment(s) to the division for approval at least thirty (30) days before beginning tank compartment closure.
- (b) The required site assessment under paragraph (5) of this rule shall be performed after receipt of division approval of the Application for Tank Compartment(s) Closure, but before completion of the tank compartment closure. Results of all samples taken during the closure of the tank compartment must be reported to the Department within sixty (60) days of collection. Samples may be taken while the compartments of the underground storage tank system that are not being permanently closed are in operation. However, samples may not be taken while the tank compartment that is being permanently closed is still in operation.
- (c) To permanently close a tank compartment, owners and/or operators shall empty and clean the compartment which is to be closed by removing all liquids and accumulated

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sludges. All tank compartments taken out of service permanently shall be filled with an inert solid material such as a cement compound, sand, gravel, etc. The inert solid material must have a specific gravity greater than one (1.0).

- (d) Tank compartment closure activities shall not damage those portions of the underground storage tank system that are not being permanently closed.
 - (e) Tank compartment closure activities shall not cause or allow a release of petroleum from the underground storage tank system into the environment.
 - (f) Paragraphs (4) and (5) of this rule shall be followed when the final tank compartment is permanently closed.
- (4) Permanent closure and changes-in-service
- (a) At least thirty (30) days before beginning either permanent closure of any portion of an underground storage tank system or a change-in-service under subparagraphs (b) and (c) of this paragraph owners and/or operators shall apply for permanent closure, unless such action is in response to corrective action. Application for permanent closure or change in service shall meet the following requirements:
 - 1. An Application for Permanent Closure of Underground Storage Tank Systems shall be submitted in a format established by the division. The application shall be completed according to the instructions provided by the division.
 - 2. The tank owner and/or operator or other responsible party shall obtain division approval of the Application for Permanent Closure prior to permanently closing the UST system or any portion thereof or effecting a change in service of the UST system, unless tank compartment closure is conducted in accordance with paragraphs (3) and (5) of this rule.
 - 3. The application shall constitute a plan for closure or change in service of the UST system, or any portion thereof.
 - 4. Change in service or closure activities shall be conducted in accordance with the plan contained in the approved Application for Permanent Closure. If alterations to the plan are required, an amended Application for Permanent Closure shall be submitted to the division for approval.
 - 5. The approved Application for Permanent Closure of Underground Storage Tank Systems shall be available for inspection upon request at the petroleum site at the time of closure.
 - 6. Division approval of the Application for Permanent Closure shall be valid for twelve (12) months following such approval. However, such approval shall not be transferable to another person during that twelve (12) month approval time.
 - 7. If permanent closure or change-in-service is not completed within twelve (12) months, the tank owner and/or operator shall submit a new Application for Permanent Closure to the division for approval at least thirty (30) days before beginning underground storage tank system closure.

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- (b) To permanently close a tank, owners and/or operators shall empty and clean it by removing all liquids and accumulated sludges. All tanks taken out of service permanently shall also be either removed from the ground or filled with an inert solid material such as a cement compound, sand, gravel, etc. The inert solid material shall have a specific gravity greater than 1.0.
- (c) Continued use of an UST system to store a non-regulated substance is considered a change-in-service. Before a change-in-service, owners and/or operators shall empty and clean the tank by removing all liquid and accumulated sludge and conduct a site assessment in accordance with paragraph (5) of this rule.
- (d) Should an owner and/or operator elect to excavate and remove a tank from the site, such excavation and removal shall be done in accordance with Appendix 1200-1-15-.07-A.
- (e) Once a tank has been excavated, it may be stored on-site or transported off-site for storage or disposal. Excavated tanks which have not been cut into sections for disposal shall be considered in storage and shall at all times, while in storage, be maintained in a vapor-free state and stored in accordance with Appendix 1200-1-15-.07-A.
- (f) Tanks shall not be stored at a UST facility unless they are maintained in a vapor-free state, stored in accordance with Appendix 1200-1-15-.07-A, and one of the following conditions are met:
 - 1.
 - (i) Tanks have been cleaned by removal of all liquids and accumulated sludges; and
 - (ii) Tanks have been purged of vapors so that any explosive levels do not exceed twenty percent (20%) of the lower explosive limit for the regulated substance; and
 - (iii) Tanks have an opening or openings installed which comprise a minimum of ten percent (10%) of the total tank surface area. Such openings will not be considered openings if they are in contact or contiguous with the ground or surface on which the tank may be resting; or
 - 2. Subparts 1(i) and (ii) of this subparagraph have been complied with and there are no remaining USTs either in use or in a temporarily closed condition at the facility; or
 - 3. Tanks which are removed from a UST facility and are intended for reuse at the same or another facility as USTs may be stored at a UST facility if the owner and/or operator meets the conditions described in subparts 1(i) and (ii) of this subparagraph, and either removes the tank off-site from a UST facility or puts it back into service within thirty (30) days of excavation.
- (g) Tanks shall be stored in a manner which does not pose safety hazards. Tanks shall be stored in a position with the tank's center of gravity closest to the ground. Tanks shall not be stacked. Tanks shall be secured so that they will not roll or slide across a level or sloping ground surface.

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[NOTE: Transportation and disposal of tanks will be subject to all applicable Federal, State, and local laws and regulations concerning the safe transportation and proper disposal of such materials.]

- (5) Assessing the site at tank closure, tank compartment closure or change-in-service.

The required site assessment shall be performed after receipt of division approval of either an Application for Permanent Closure of Underground Storage Tank System(s) or an Application for Closure of Tank Compartment(s), but before completion of either the permanent closure, tank compartment closure or a change-in-service. The required site assessment shall be performed in accordance with guidance provided by the division.

- (a) Before permanent closure of a tank or a tank compartment or a change-in-service is completed, owners and/or operators shall measure for the presence of a release where contamination is most likely to be present at the UST site. The requirements of this subparagraph are satisfied if one of the external release detection methods allowed in rule 1200-1-15-.04(3)(e) and (f) is operating in accordance with the requirements in rule 1200-1-15-.04(3) at the time of closure, and indicates no release has occurred. Sampling shall meet the following requirements:
 - 1. In selecting sample types, sample locations, and measurement methods, owners and/or operators shall consider the method of closure, the nature of the stored substance, the type of backfill, the depth to ground water, and other factors appropriate for identifying the presence of a release.
 - 2. At least one day before samples are taken, the owner and/or operator shall notify the division concerning the schedule for sample collection.
- (b) Results of all samples taken during change in service or closure of the underground storage tank system or closure of a tank compartment shall be reported to the division within sixty (60) days of collection. Samples shall not be taken while the underground storage tank system is in operation, except when tank compartment closure is being conducted in accordance with paragraph (3) of this rule. Sample results shall be submitted as an attachment to either a Permanent Closure Report for Underground Storage Tank Systems or a Permanent Closure Report for Tank Compartments.
- (c) The Permanent Closure Report for Underground Storage Tank Systems shall be submitted in a format established by the division. The Permanent Closure Report for Underground Storage Tank Systems shall be completed in accordance with the instructions provided by the division.
- (d) The Permanent Closure Report for Tank Compartments shall be submitted in a format established by the division. The Permanent Closure Report for Tank Compartments shall be completed in accordance with the instructions provided by the division.
- (e) The report, either the Permanent Closure Report for Underground Storage Tank Systems or the Permanent Closure Report for Tank Compartments, shall include, but not be limited to, the following information:
 - 1. The facility identification number assigned to the facility by the division;
 - 2. Facility name and address;

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3. An updated post-closure site map;
 4. Sampling, including field screening and laboratory analytical results;
 5. Information concerning the removal, storage and/or disposal of tanks, piping and other ancillary underground equipment; and
 6. Information concerning the removal, remediation and/or disposal of petroleum, petroleum waste, petroleum contaminated soil and/or ground water.
- (f) If contaminated soils, contaminated ground water, or free product as a liquid or vapor is discovered under subparagraph (a) of this paragraph, or by any other manner, owners and/or operators shall begin release response and corrective action in accordance with rule 1200-1-15-.06.
- (6) Applicability to previously closed UST systems.
- When directed by the division, the owner and/or operator of an UST system permanently closed before December 22, 1988 shall assess the site and close the UST system in accordance with this rule if releases from the UST may, in the judgment of the division, pose a current or potential threat to human health and the environment.
- (7) Closure records.
- Owners and/or operators shall maintain records in accordance with rule 1200-1-15-.03(5) that are capable of demonstrating compliance with closure requirements under this rule. The results of the site assessment required in paragraph (5) of this rule shall be maintained for at least three (3) years after completion of permanent closure or change-in-service in one of the following ways:
- (a) By the owners and/or operators who took the UST system out of service;
 - (b) By the current owners and/or operators of the UST system site; or
 - (c) By mailing these records to the division if they cannot be maintained at the closed facility.

APPENDIX 1200-1-15-.07-A

Removal Of Underground Tanks

- (1) Preparation
 - (a) Drain product piping into the tank, being careful to avoid any spillage. Cap or remove product piping.
 - (b) Remove liquids and residues from the tank by using explosion-proof or air-driven pumps. Pump motors and suction hoses shall be bonded to the tank or otherwise grounded to prevent electrostatic ignition hazards. It may be necessary to use a hand pump to remove the last few inches of liquid from the bottom of the tank.

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NOTE: (The Federal Resource Conservation and Recovery Act (RCRA) 42 U.S.C. Section 6901 et seq., and the Tennessee Hazardous Waste Management Act (HWMA) Part 1 T.C.A. §68-46-101 et seq. place restrictions on disposal of certain residues that may be present in some underground storage tanks. Residues from tanks that have held leaded gasoline should be treated with extreme caution. Lead compounds and other residues in the tank may be classified as hazardous wastes).

- (c) Excavate to the top of tank.
- (d) Remove the fill pipe, gauge pipe, vapor recovery truck connection, submersible pumps, and other tank fixtures. Remove the drop tube, except when it is planned to vapor-free the tank by using an eductor. Cap or remove all non-product lines, such as vapor recovery lines, except the vent line. The vent line shall remain connected until the tank is purged. Temporarily plug all other tank openings so that all vapors will exit through the vent line during the vapor-freeing process.

(2) Purging

- (a) Remove flammable vapors by one of the methods described in subparagraphs (b) through (e) of this paragraph, or as required by local codes. These methods provide a means for temporary vapor-freeing of the tank atmosphere. However, it is important to recognize that the tank may continue to be a source of flammable vapors even after following the vapor-freeing procedures described in subparagraphs (b) through (e) of this paragraph. For this reason, caution shall always be exercised when handling or working around tanks that have stored flammable or combustible liquids. Before initiating work in the tank area or on the tank, a combustible gas indicator shall be used to assess vapor concentrations in the tank and work area. All work shall be done in accordance with Paragraph (3), "Testing"
- (b) Vent all vapors from the tank at a minimum height of twelve (12) feet above grade and three (3) feet above any adjacent roof lines until the tank is purged of flammable vapors. The work area shall be free from sources of ignition.
- (c) Flammable and combustible vapors may be purged with an inert gas such as carbon dioxide (CO₂) or nitrogen (N₂). This method is not to be utilized if the tank is to be entered for any reason, as the tank atmosphere will be oxygen deficient. The inert gas is to be introduced through a single tank opening at a point near the bottom of the tank at the end of the tank opposite the vent. When inert gases are used, they shall be introduced under low pressure to avoid the generation of static electricity. When using CO₂ or N₂, pressures in the tank shall not exceed five (5) pounds per square inch gauge.

Caution: The process of introducing compressed gases into the tank may create a potential ignition hazard as the result of the development of static electrical charges. The discharging device shall therefore be grounded. Explosions have resulted from the discharging of CO₂ fire extinguishers into tanks containing a flammable vapor-air mixture. CO₂ extinguishers shall not be used for inerting flammable atmospheres.

- (d) If the method described in (c) is not practical, the vapors in the tank may be displaced by adding solid carbon dioxide (dry ice) to the tank in the amount of at least 1.5 pounds per 100 gallons of tank capacity. The dry ice should be crushed

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and distributed evenly over the greatest possible area in the tank to promote rapid evaporation. As the dry ice vaporizes, flammable vapors will flow out of the tank and may surround the area. Therefore, where practical, plug all tank openings except the vent after introducing the solid CO₂ and continue to observe all normal safety precautions regarding flammable or combustible vapors. Make sure that all of the dry ice has evaporated before proceeding.

- (e) Flammable vapors may be exhausted from the tank by one of two methods of tank ventilation listed below:

1. Ventilation using an eductor-type air mover usually driven by compressed air. The eductor-type air mover shall be properly bonded to prevent the generation and discharge of static electricity. When using this method, the fill (drop) tube shall remain in place to ensure ventilation at the bottom of the tank. Tanks equipped with fill (drop) tubes that are not removable should be purged by this method. An eductor extension shall be used to discharge vapors a minimum of twelve (12) feet above grade and at least three (3) feet above any adjacent roof line.
2. Ventilation with a diffused air blower. When using this purging method, it is imperative that the air-diffusing pipe is properly bonded to prevent the discharge of a spark. Fill (drop) tubes shall be removed to allow proper diffusion of the air in the tank. Air supply should be from a compressor that has been checked to ensure a clean air supply and is free from volatile vapors. Air pressure in the tank shall not exceed five (5) pounds per square inch gauge.

(3) Testing

- (a) The tank atmosphere and the excavation area are to be regularly tested for flammable or combustible vapor concentrations until the tank is removed from both the excavation and the site. Such tests are to be made with a combustible gas indicator which is properly calibrated according to the manufacturer's instructions and which is thoroughly checked and maintained in accordance with the manufacturer's instructions. Persons responsible for testing shall be completely familiar with the use of the instrument and the interpretation of the instrument's readings.
- (b) The tank vapor space is to be tested by placing the combustible gas indicator probe into the fill opening with the drop tube removed. Readings should be taken at the bottom, middle, and upper portions of the tank, and the instrument should be cleared after each reading. If the tank is equipped with a non-removable fill tube, readings are to be taken through another opening. Liquid product shall not enter the probe. Readings of twenty percent (20%) or less of the lower flammable limit shall be obtained before the tank is considered safe for removal from the ground.
- (c) Tanks purged with an inert gas shall be sampled with an oxygen indicator and the oxygen content shall be considered while interpreting combustible gas indicator results.

(4) Removal

- (a) After the tank has been freed of vapors and before it is removed from the excavation, plug or cap all accessible holes. One plug shall have a one-eighth of an inch vent

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hole to prevent the tank from being subjected to excessive differential pressure caused by temperature changes. The tank shall always be positioned with this vent plug on top of the tank during subsequent transport and storage.

- (b) Excavate around the tank to uncover it for removal. Remove the tank from the excavation and place it on a level surface. Use wood blocks to prevent movement of the tank after removal and prior to loading on a truck for transportation. Use screwed (boiler) plugs to plug any corrosion holes in the tank shell.
- (c) Precautions shall be taken to assure any vapors left in the tank do not reach a combustible level. If this situation occurs, the tank shall be purged according to Section (2).
- (d) Before the tank is removed from the site, the tank atmosphere shall be checked with a combustible gas indicator to ensure that it does not exceed twenty percent (20%) of the lower flammable limit.
- (e) The tank shall be secured on a truck for transportation to the storage or disposal site with the one-eighth of an inch vent hole located at the uppermost point on the tank. Tanks shall be transported in accordance with all applicable local, state, and federal laws and regulations.
- (f) Tanks shall be labeled after removal from the ground but prior to removal from the site. Regardless of the condition of the tank, the label shall contain a warning against certain types of reuse. The former contents and present vapor state of each tank, including vapor-freeing treatment and data shall also be indicated. The label shall be similar to the following in legible letters at least two (2) inches high:

Tank Has Contained Leaded Gasoline*

Not Vapor Free

Not Suitable For Storage Of Food Or Liquids

Intended For Human Or Animal Consumption

Date Of Removal: Month/Day/Year

*Or other flammable/combustible liquid. Use the applicable designation, for example, DIESEL.

Tanks that have held leaded motor fuels (or whose service history is unknown) shall also be clearly labeled with the following information:

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Tank Has Contained Leaded Gasoline

Lead Vapors May Be Released If Heat

Is Applied To The Tank Shell

Storage Of Used Tanks

Storage Procedures

- (a) Tanks shall be vapor-freed before being placed in storage. Tanks shall also be free of all liquids and residues. All tank openings shall be tightly plugged or capped, with one plug having a one-eighth of an inch vent hole to prevent the tank from being subjected to excessive differential pressure caused by temperature changes. Tanks shall be stored with the vented plug at the highest point on the tank. All tanks shall be labeled.
- (b) Used tanks shall be stored in secure areas where the general public will not have access.

Rule 1200-1-15-.09 Administrative Guidelines and Procedures for the Tennessee Petroleum Underground Storage Tank Fund. is amended by deleting it in its entirety and replacing it with the following:

1200-1-15-.09 ADMINISTRATIVE GUIDELINES AND PROCEDURES FOR THE TENNESSEE PETROLEUM UNDERGROUND STORAGE TANK FUND.

(1) Purpose.

This rule establishes administrative guidelines and procedures to determine the manner in which disbursements are made from the Tennessee Petroleum Underground Storage Tank Fund and to implement the purposes and objectives of the Tennessee Petroleum Underground Storage Tank Act.

(2) Applicability.

- (a) Requirements of this rule apply to all owners and operators of an underground storage tank system as defined in rule 1200-1-15-.01(4) except as otherwise provided for in rule 1200-1-15-.01(2)(b). However, the requirements of this rule do not apply to those tanks owned by state and federal entities whose debts and liabilities are the debts and liabilities of a state or the United States.
- (b) Petroleum site owners eligible for fund reimbursement shall only be reimbursed for those fund eligible and reasonable costs which accrued on or after July 1, 2002.

(3) Fund Eligibility Requirements.

- (a) Every owner of an UST is required to register that tank with the division in accordance with rule 1200-1-15-.03(1). The owner and/or operator is required to annually pay the required fee for each tank compartment described in rule 1200-1-15-.10(2) and rule 1200-1-15-.10(5)(c). Owners and/or operators satisfying the requirements of this paragraph will have established fund eligibility. Before the owner and/or operator or petroleum site owner will receive fund benefit, the applicable entry level amount

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to the fund must be expended as approved costs by the owner and/or operator or petroleum site owner and/or financial assurance provider. The applicable entry level is the entry level in effect on the date of the release as set forth in subparagraph (7)(b) of this rule.

- (b) Every owner or operator of an UST is required to maintain fund eligibility. Requirements to maintain eligibility are as follows:
 - 1. The owner or operator shall remain in substantial compliance for each UST. If a UST does not remain in substantial compliance, the owner or operator is not eligible for fund benefits for the site containing the non-complying UST.
 - 2. Annual payment of underground storage tank fees for tanks and/or tank compartments is required for each UST until such time as the permanent closure of the tank or the tank compartment or change-in-service requirements of rule 1200-1-15-.07(3) through rule 1200-1-15-.07(5) are satisfied.
 - 3. The owner or operator shall maintain the records as required in Chapter 1200-1-15 and submit or make them available to the division upon request or as directed in regulation.
 - 4. All records maintained as required in part (b)3. of this subparagraph shall be retained by the owner and/or operator until one of the following is accomplished:
 - (i) Closure requirements of rule 1200-1-15-.07(4) through 1200-1-15-.07(5) are satisfied;
 - (ii) Ownership of an UST, and all records pertaining thereto, are transferred to a new owner; or
 - (iii) Owner or operator is instructed otherwise by the division.
- (4) Loss, Restoration, and Establishment of Fund Eligibility.
 - (a) If at the time of discovery of a release, the division determines that an owner and/or operator has failed to establish fund eligibility in accordance with subparagraph (3)(a) or has lost fund eligibility in accordance with subparagraph (4)(b), corrective action costs and/or third party damages associated with that release are not eligible for coverage by the fund.
 - (b) If at any time the division determines that an owner and/or operator has failed to meet the requirements of paragraph (3) of this rule, the division will provide notice to the owner and/or operator of such non-compliance. The owner and/or operator shall have thirty (30) days after the date of such notice sent by certified mail as evidenced by return receipt to provide evidence of compliance with all fund eligibility requirements, or such other time as the division may allow. If, after this time period, the owner and/or operator fails to resolve the non-compliance, the director shall issue a Notice of Fund Ineligibility and enforcement actions which may include penalty assessment may be initiated. The owner and/or operator shall have sixty (60) days after the date of Notice of Fund Ineligibility sent by certified mail as evidenced by return receipt to place in force alternate financial assurance required in Rule 1200-1-15-.08.
 - (c) An owner and/or operator who has failed to establish fund eligibility in accordance with the provisions of part (3)(a) of this rule or who has lost fund eligibility in

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accordance with the provisions of subparagraph (b) of this paragraph shall comply with the following in order to establish or restore fund eligibility:

1. Pay all annual tank fees and late payment penalties owed;
2. Pay all civil penalties owed;
3. Demonstrate through a division approved site check there have been no releases from the UST system(s) at this site; and
4. The division will conduct an inspection of the owner and/or operator's petroleum site and underground storage tank systems. The owner and/or operator shall cure, to the satisfaction of the division, any noted deficiencies or violations discovered by the division personnel during this inspection within forty-five (45) days, or such other time period as the division may allow, of the date of the notice of such deficiencies to the owner and/or operator.

(e) An owner and/or operator may petition the Board for a hearing of the Commissioner's determination provided a written petition is submitted to and received by the Commissioner within thirty (30) days of receipt of the division's determination of fund ineligibility or determination that the responsible party has failed to restore fund eligibility, pursuant to the terms of the Act and this Rule. The Commissioner's determination shall be final and not subject to review unless the written petition for hearing is submitted and received within this time frame. The written petition must set forth the basis for the appeal as required by the Administrative Procedures Act. T.C.A. §4-5-101 et seq, and the Rules promulgated thereunder, particularly Rule 1360-4-1-.05

(f) Within thirty (30) days of meeting the requirements to either restore or establish fund eligibility in accordance with subparagraph (c) of this paragraph, the division will notify the owner and/or operator of the date that fund eligibility was restored. The fund will not cover either investigative or corrective action costs or third party liability claims associated with a release which occurred during the time of fund ineligibility.

(5) Annual Fee Assessment.

- (a) As part of the eligibility requirements to participate in the liability limitations and reimbursement benefits of the fund, an UST owner or operator shall pay an annual tank and/or tank compartment fee set by the Board.
- (b) Each year UST owners or operators will be notified by the division of the amount of the required tank and/or tank compartment fee.

(6) Authorized Disbursements From the Fund.

(a) Whenever, in the Commissioner's determination, an eligible owner and/or operator or petroleum site owner has a release of petroleum from an underground storage tank and the owner and/or operator or petroleum site owner has been found to be eligible for fund coverage, the Department shall, subject to the provisions of this rule, disburse monies available in the fund to provide for:

1. Emergency response activities, investigation, and assessment of sites contaminated by a release of petroleum in accordance with the requirements of rule 1200-1-15-.05 through 1200-1-15-.06;

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2. The rehabilitation of sites contaminated by a release of petroleum, which may consist of clean-up of affected soil and groundwater, using cost effective alternatives that are technologically feasible and reliable, and that provide adequate protection of the public health, safety and welfare and minimize environmental damage, in accordance with release response, remediation and risk management requirements of rule 1200-1-15-.06;
 3. The interim replacement and permanent restoration of potable water supplies.
- (b) Monies held in the fund may be disbursed for making payments to third parties who bring suit relative to an UST release against the owner or operator of an UST or petroleum site owner who is eligible for fund coverage when such third party obtains a final judgment in that action enforceable in Tennessee.
 - (c) Costs incurred by the division in the administration of the provisions of this Rule or authorized under T.C.A. §68-215-101 et seq. shall be charged to the fund.
 - (d) The fund shall be available to the Board and the Commissioner for expenditures for the purposes of providing for the investigation, identification, and for the reasonable and safe cleanup, including monitoring and maintenance of petroleum sites within the state as provided in T.C.A. §68-215-101 et seq.
 - (e) The Commissioner may enter into contracts and use the fund for those purposes directly associated with identification, investigation, containment, and cleanup, including monitoring and maintenance prescribed above including:
 1. Hiring consultants and personnel;
 2. Purchase, lease or rental of necessary equipment; and
 3. Other necessary expenses.
 - (f) The Commissioner will pay each approved claim of the fund in chronological order based upon the date the claim is submitted for payment.
 - (g) The Commissioner will not authorize any disbursement from the fund for costs for which the owner and/or operator or petroleum site owner receives payment from another insurance carrier or other source. Further, the division shall acquire by subrogation the right of the owner and/or operator of the underground storage tank system from which the release occurred or the petroleum site owner, responsible or liable for the release.
- (7) Scope of Fund Coverage.
- (a) The fund will provide to eligible owners or operators or petroleum site owners coverage for the cost of investigation and corrective action resulting from the accidental release of petroleum from an UST storing petroleum.
 - (b) Owners or operators of USTs or petroleum site owners who are eligible for fund coverage shall meet the per site per occurrence financial responsibility requirements specified in parts 1 through 6 and illustrated in Table 3.

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1. If the date of the release was after January 1, 1974 and before July 1, 1988 and the release was reported to the department before April 11, 1990, the financial responsibility requirements for eligible UST owners or operators or petroleum site owners for taking corrective action will be seventy-five thousand dollars (\$75,000) and compensation of third parties will be one hundred fifty thousand dollars (\$150,000).
2. If the date of release was between July 1, 1988 and June 30, 1989, the financial responsibility requirements for eligible UST owners or operators or petroleum site owners for taking corrective action will be seventy-five thousand dollars (\$75,000) and compensation of third parties will be one hundred fifty thousand dollars (\$150,000).
3. If the date of release was between July 1, 1989 and April 30, 1990, the financial responsibility requirements for eligible UST owners or operators or petroleum site owners for taking corrective action will be fifty thousand dollars (\$50,000) and compensation of third parties will be one hundred fifty thousand dollars (\$150,000).
4. If the date of release was between May 1, 1990 and April 4, 1995, the financial responsibility requirements for eligible UST owners or operators or petroleum site owners for corrective action and for compensation for third party claims will be as follows based on the number of tanks owned or operated:
 - (i) 1 to 12 tanks, ten thousand dollars (\$10,000) for taking corrective actions and ten thousand dollars (\$10,000) for compensation of third parties;
 - (ii) 13 to 999 tanks, twenty thousand dollars (\$20,000) for taking corrective actions and thirty-seven thousand five hundred dollars (\$37,500) for compensation of third parties; or
 - (iii) 1,000 or more tanks, fifty thousand dollars (\$50,000) for taking corrective actions and two hundred twenty-five thousand dollars (\$225,000) for compensation of third parties.
5. If the date of release was between April 5, 1995 and July 1, 2005, the financial responsibility requirements for eligible UST owners or operators or petroleum site owners shall be as follows based on the number of tanks owned or operated by the tank owner at the time of the release:
 - (i) For corrective action costs:
 - (I) 1 to 12 tanks, ten percent (10%) of the total corrective action costs expended in an amount not to exceed ten thousand dollars (\$10,000);
 - (II) 13 to 999 tanks, twenty percent (20%) of the total corrective action costs expended in an amount not to exceed twenty thousand dollars (\$20,000); or

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- (III) 1,000 or more tanks, fifty thousand dollars (\$50,000);
- (ii) For compensation of third parties claims:
 - (I) 1 to 12 tanks, ten thousand dollars (\$10,000) for compensation of third parties;
 - (II) 13 to 999 tanks, thirty-seven thousand five hundred dollars (\$37,500) for compensation of third parties; or
 - (III) 1,000 or more tanks, two hundred twenty-five thousand dollars (\$225,000) for compensation of third parties.
- 6. If the date of the release was on or after July 1, 2005, the financial responsibility requirements for eligible UST owners or operators or petroleum site owners for taking corrective action will be twenty thousand dollars (\$20,000) and compensation of third parties will be twenty thousand dollars (\$20,000).

TABLE 3

OWNER/OPERATOR FINANCIAL RESPONSIBILITY PER SITE PER OCCURRENCE

DATE OF RELEASE	NUMBER OF TANKS		
	1 - 12 Tanks	13 - 999 Tanks	1000+ Tanks
After January 1, 1974 and Before July 1, 1988 And Reported before April 11, 1990	\$75,000 Clean-up/ \$150,000 third party	\$75,000 Clean-up/ \$150,000 third party	\$75,000 Clean-up/ \$150,000 third party
Between July 1, 1988 and June 30, 1989	\$75,000 Clean-up/ \$150,000 third party	\$75,000 Clean-up/ \$150,000 third party	\$75,000 Clean-up/ \$150,000 third party
Between July 1, 1989 and April 30, 1990	\$50,000 Clean-up/ \$150,000 third party	\$50,000 Clean-up/ \$150,000 third party	\$50,000 Clean-up/ \$150,000 third party
Between May 1, 1990 and April 4, 1995	\$10,000 Clean-up/ \$10,000 third party	\$20,000 Clean-up/ \$37,500 third party	\$50,000 Clean-up/ \$225,000 third party
Between April 5, 1995 And June 30, 2005	10% of Clean-up Cost not to exceed \$10,000 \$10,000 third party	20% of Clean-up cost not to exceed \$20,000 \$37,500 third party	\$50,000 Clean-up/ \$225,000 third party
On or after July 1, 2005	\$20,000 Clean-up/ \$20,000 third party	\$20,000 Clean-up/ \$20,000 third party	\$20,000 Clean-up/ \$20,000 third party

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- (c) The fund shall be responsible to eligible UST owners or operators or petroleum site owners for eligible corrective action costs above the entry level to the fund in an amount not to exceed one million dollars (\$1,000,000) per site per occurrence. Likewise, the fund shall be responsible to eligible UST owners or operators or petroleum site owners for court awards involving third party claims above the entry level into the fund in an amount not to exceed one million dollars (\$1,000,000) per site per occurrence.
- (d) If the date of the release is on or after September 1, 2005, the owner and/or operator may apply for a reduction of the financial responsibility requirement for corrective action set forth in part (b)6 of this paragraph. Application shall be made using a format established by the division and in accordance with instructions provided by the division.
1. The tank owner and/or operator must demonstrate to the satisfaction of the division that each UST system at the facility meets or exceeds the criteria for reduction of the financial responsibility amount set forth in the table in this subparagraph. Such demonstration may include, but not be limited to:
 - (i) Submittal of verifying documentation to the division; and/or
 - (ii) On-site verification by the division.
 2. For each criterion met there shall be an associated reduction in the financial responsibility amount. However, the maximum percentage reduction in the financial responsibility amount per occurrence shall not exceed fifty percent (50 %).

CRITERIA	PERCENTAGE REDUCTION
Double Wall Tank(s)	10 %
Secondary Containment Chase Piping Enclosing Fiberglass Primary Piping or Flexible Plastic Piping with Containment Sumps at Piping Joints	10 %
Containment Sumps at Submersible Turbine Pumps	10 %
Containment Sumps under Dispensers	10 %
Continuous In-Tank Leak Detection System	10 %

3. If a criterion is not applicable to one or more of the UST systems at the facility, then the conditions of part 1 of this subparagraph shall have been met if every UST systems at the facility for which the criterion is applicable meets that criterion. For example, the criterion for a containment sump under a dispenser is not applicable to a UST system used to store waste oil or used oil.
4. Upon confirmation by the division that a tank owner and/or operator has met one or more of the criteria for reduction of the financial responsibility amount set forth in the table in this subparagraph, the tank owner and/or operator will be sent correspondence setting forth the new reduced financial responsibility amount.

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(8) Fund Ineligible Costs.

- (a) Costs of replacement, repair, removal, maintenance, and/or retrofitting of affected tanks and associated piping and any costs not integral to site rehabilitation shall not be eligible for payment or reimbursement by the fund. Costs of replacement, repair, removal maintenance, and/or retrofitting of tanks and associated piping to comply with the requirements of rule 1200-1-15-.02(2) and (3) shall not be eligible for fund payment or reimbursement. Replacement of asphalt or concrete shall not be eligible for fund payment or reimbursement.
- (b) The cost of equipment purchases other than routinely required supplies which are expended at a given site or equipment which shall be installed at a site to implement a Corrective Action Plan shall not be charged as a lump sum to the cost of rehabilitating any given site at which funds are being claimed for containment, investigative, or corrective action costs. Examples of equipment which could not be charged to a specific site would include: drilling rigs, earth moving equipment, ground water sampling pumps, and photoionization detectors. Examples of equipment which could be charged to a specific site would include: bailers, sample containers, etc. Hourly charges for equipment may be established in the cost proposal submitted for each major phase of work. These hourly rates shall be competitive with similar charges by other approved contractors, or they may be rejected by the division if they are determined to represent unreasonable costs.
- (c) The owner or operator or petroleum site owner financial responsibility requirements amounts as specified in subparagraph (7)(b) of this rule are not eligible for reimbursement from the fund. Proof of payment of these initial amounts is required prior to reimbursement of any costs. The owner or operator or petroleum site owner financial responsibility requirement for taking corrective action cannot include any cost defined as fund ineligible in subparagraphs (a) and (b) of this paragraph.
- (d) Costs of removing underground storage tanks, including any expenditure associated with the proper closure of a tank in compliance with rule 1200-1-15-.07 shall not be eligible for fund payment or reimbursement.

(9) Fund Obligations.

- (a) Contingent upon availability of funds, the Commissioner will make obligations from the fund when:
 - 1. A cost proposal for containment, investigative, or corrective actions, submitted in accordance with paragraph (10) of this rule, is approved by the division;
 - 2. A judgment for a third party claim is submitted for payment in accordance with paragraphs (6), (11) and (12) of this rule;
 - 3. A payment application is received for containment, investigative, or corrective action work performed from July 1, 1988 until April 15, 1990, subject to a determination of reasonable costs by the division. Fund eligibility from July 1, 1988 until April 15, 1990 shall be determined by fee payment as required by the Tennessee Petroleum Underground Storage Tank Act;

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4. A payment application is received for initial release response, abatement measures, and initial free product removal under the terms of subparagraph (10)(d) of this rule;
 5. A payment application is received and approved by the division for costs associated with providing an alternate water supply to a person whose water supply has been contaminated by a release of petroleum; or
 6. The Commissioner or Board determines it is necessary to provide for containment, investigation, identification, reasonable and safe cleanup, and as otherwise provided in the Tennessee Petroleum Underground Storage Tank Act.
- (b) If the unobligated balance of the fund is less than the total amount associated with payment applications, cost proposals, and third party judgements which have been accepted by the Commissioner, to the extent allowed by available funds, funds will be obligated in the chronological order in which the claims were submitted, except for the provisions of subparagraph (c) of this paragraph.
- (c) Obligations of funds required for satisfying fund eligible payment applications for work performed under part (a)3 of this paragraph or judgments for third party claims which were rendered prior to April 15, 1990, for releases discovered from July 1, 1988 until April 15, 1990, will be given priority over payment applications and cost proposals for releases which occur after April 15, 1990.
- (d) All claims against the fund are clearly obligations only of the fund and not of the State, and any amounts required to be paid under this part are subject to the availability of sufficient monies in the fund. The full faith and credit of the State shall not in any way be pledged or considered to be available to guarantee payment from such fund.
- (10) Requirements for Fund Coverage of Corrective Action Costs. An eligible owner or operator or petroleum site owner conducting UST corrective actions is entitled to coverage of reasonable costs from the fund, subject to the provisions set forth in this paragraph. The division shall acquire by subrogation the right of the owner and/or operator or petroleum site owner to recover from any person responsible or liable for the release, other than the owner and/or operator of the underground storage tank system from which the release occurred, the amount paid by the fund to the owner and/or operator or petroleum site owner.
- (a) Upon confirmation of a release in accordance with rule 1200-1-15-.05(3) or after a release from the UST system is identified in any other manner, owners and operators or petroleum site owners shall comply with the requirements of rule 1200-1-15-.06 as necessary to investigate the release, characterize the site and control any hazards posed by the release in order to stabilize the site, prevent significant risk to human health and safety, and/or continuing damage to the environment.
- (b) Upon confirmation and reporting of a release in accordance with the requirement of rule 1200-1-15-.05(1) through rule 1200-1-15-.05(3), the owner or operator or petroleum site owner shall select a contractor from the division's list of approved contractors if the owner or operator or petroleum site owner expects to apply for fund benefits. The division shall be notified in writing of such a selection within thirty (30) days or other time frame specified by the division. A contractual agreement

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shall be established between the owner or operator or petroleum site owner and the contractor. The division shall be provided a copy of the contractual agreement.

- (c) Effective December 22, 1998, upon confirmation and reporting of a release in accordance with the requirements of rule 1200-1-15-.05(1) through rule 1200-1-15-.05(3), the owner and/or operator shall submit documentation to the division verifying that the tanks are in compliance with the upgrading and performance standards set forth in rule 1200-1-15-.02(2)(a) and (3)(a) and (b). On the effective date of this rule, upon confirmation and reporting of a release in accordance with the requirements of rule 1200-1-15-.05(1) through rule 1200-1-15-.05(3), the owner and/or operator shall submit documentation to the division verifying the performance of release detection as required by rule 1200-1-15-.04 at the time of the release. The owner and/or operator shall submit this documentation to the division within thirty (30) days of the date the release is confirmed.
- (d) If initial response or hazard control measures conducted in accordance with rules 1200-1-15-.06(3) through rule 1200-1-15-.06(4), are required to properly stabilize a site and prevent significant continuing damage to the environment or risk to human health, and the cost of such required measures is expected to exceed ten thousand dollars (\$10,000), then the owner or operator or petroleum site owner or the approved corrective action contractor may contact the division to obtain verbal or written approval to allow additional expenditures prior to the submittal of a cost proposal. Additional expenditures may be authorized by the division up to a total of thirty thousand dollars (\$30,000) which may be reimbursable from the fund to achieve site stabilization and immediate protection of human health or the environment. Such approval may be given following the actual expenditures if immediate actions were necessary to protect human health or the environment and division personnel were unavailable. In such a case, the division shall be notified of the actions taken by no later than one (1) working day after any such actions.
- (e) Following completion of necessary site stabilization actions as described in subparagraph (d) of this paragraph, subsequent investigation, risk evaluation, and remediation shall be performed by approved contractors and in accordance with the requirements of rule 1200-1-15-.06. Unless directed to do otherwise by the division, prior to initiating any subsequent investigation, risk evaluation or remediation, the owner and/or operator or the petroleum site owner shall, through the assistance of the selected approved contractor, prepare and submit to the division a cost proposal for conducting the proposed investigation, risk evaluation or remediation. Cost proposals shall be prepared in accordance with guidance provided by the division and in a format established by the division.
- (f) Upon review of a cost proposal submitted in accordance with subparagraph (e) of this paragraph the division may:
 - 1. Accept the cost proposal and authorize work to be initiated; or
 - 2. Request a modification to or clarification of the cost proposal if projected costs are determined not to be reasonable.
- (g) Unless directed to do otherwise by the division, in addition to the requirements of (d) and (e) of this paragraph, the owner or operator or petroleum site owner shall upon submittal of a cost proposal for a site investigation, also submit an estimate of the total cost of remediation for the site in a format required by the division, which

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shall be used solely for the purpose of the Board and the division in projecting future funding requirements for the fund. The total estimated cost of remediation for a site shall be updated by the owner or operator or petroleum site owner in accordance with a schedule required by the division and as more complete information regarding a site becomes available.

- (h) Upon acceptance of a cost proposal by the division, sufficient monies will be obligated from the fund for completion of the particular phase of work for which the cost proposal was submitted and authorization will be provided for the initiation of the proposed action. Obligation of funds shall be subject to the availability of funds at the time of acceptance of the cost proposal.
- (i) Corrective actions performed prior to acceptance of an associated cost proposal may not be eligible for reimbursement.
- (j) If the cost of completing any of the corrective actions of subparagraph (e) of this paragraph, is expected to exceed the amount of an accepted cost proposal, an amended cost proposal shall be submitted and accepted to allow additional funds to be obligated.
- (k) Any corrective action which is carried out in response to any discharge, release, or threatened release of petroleum from an UST shall be conducted in accordance with the requirements of rules 1200-1-15-.06 and subparagraphs (a) through (e) of this paragraph.
- (l) The owner or operator or petroleum site owner or the selected corrective action contractor shall keep and preserve detailed records demonstrating compliance with approved investigative and corrective action plans and all invoices and financial records associated with costs for which reimbursement will be requested. These records shall be kept for at least three years after corrective action has been completed for a site.
- (m) Any approved corrective action shall be implemented in a manner acceptable to the division in accordance with an approved corrective action plan, if applicable, in order for the owner or operator or petroleum site owner to be eligible for the reimbursement of costs.
- (n) An eligible owner or operator conducting UST response actions from July 1, 1988 until April 15, 1990, relative to any discharge, release or threatened release of petroleum from an UST, is entitled to reimbursement of reasonable costs above entry level from the fund but is exempted from the requirements of subparagraphs (b) through (j) of this paragraph, provided that corrective actions were carried out in accordance with a plan approved by the division.
- (o) If corrective actions which were initiated during the time period referenced in subparagraph (n) of this paragraph are still continuing on April 15, 1990, the division may require submittal of cost proposals for any remaining phases of work and for the total projected cost of the remediation.
- (p) If the contractor performing corrective actions as described in subparagraph (o) of this paragraph is not an approved contractor, the division may authorize the continued use of that contractor.

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- (q) If a contractor is performing corrective action at a site prior to development of an approved contractor list, the division may authorize the continued use of that contractor.
- (r) The tank owner and/or operator or petroleum site owner, and his/her representative or Corrective Action Contractor, shall gather and maintain documentation and records necessary to verify the necessity for any implemented corrective action and any claim for reimbursement from the fund. Further, the tank owner and/or operator or petroleum site owner, and his/her representative or Corrective Action Contractor, shall fully cooperate with any audit which the Commissioner, or his authorized representatives, conducts to verify the expenditures and costs contained within documentation submitted to the department for reimbursement from the fund. Therefore, the tank owner and/or operator or petroleum site owner, and his/her representative or Corrective Action Contractor, shall produce any records, data, documents, information, and personnel for interviews as necessary in the Commissioner's determination to fully and completely conduct an audit.

(11) Requirements for Fund Coverage of Third Party Claims.

An eligible owner or operator or petroleum site owner is entitled to fund coverage for third party damages caused by the release of petroleum from an underground storage tank system, subject to the requirements set forth in this paragraph. The division shall acquire by subrogation the right of the owner/operator or petroleum site owner to recover the amount of damages paid to any third party from any person responsible or liable for the release, other than the owner and/or operator of the underground storage tank system from which the release occurred.

To assert a claim for payment or reimbursement of a third party claim, an eligible owner or operator or petroleum site owner shall comply with each of the following:

- (a) Notify the division in writing within twenty-one (21) days upon the receipt of written notice of the third party liability suit. Thereafter, the owner and/or operator or petroleum site owner shall submit to the division a report which accurately reflects the status of the lawsuit every four (4) months, until the litigation is resolved. The owner and/or operator or petroleum site owner shall also notify the division in writing fourteen (14) days in advance of any settlement conference or settlement agreement;
- (b) The owner or operator is in substantial compliance at the time the release occurred at the time the third party suit is filed, and at the time the application for reimbursement is submitted and provides documentation to the division of substantial compliance;
- (c) Copies of the invoices for all costs for which payment is sought together with a copy of the bid proposal submitted to the owner or operator or petroleum site owner by the Corrective Action Contractor retained to perform the corrective action shall be provided to the division with the application for reimbursement as set forth in paragraph (14) of this rule.
- (d) The third party obtains a final judgment enforceable in Tennessee or pursuant to a settlement reviewed and approved by the division. The underground storage tank system owner and/or operator or petroleum site owner shall file a motion with the court requesting that the final judgment specify the type and amount of all damages awarded to the third party(ies);

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- (e) The final judgment is for an amount greater than the fund entry level in effect on the date of release.
 - (f) The tank owner and/or operator or petroleum site owner, and his/her representative or Corrective Action Contractor, shall gather and maintain documentation and records necessary to verify the necessity for any implemented corrective action and any claim for reimbursement from the fund. Further, the tank owner and/or operator or petroleum site owner, and his/her representative or Corrective Action Contractor, shall fully cooperate with any audit which the Commissioner, or his authorized representatives, conducts to verify the expenditures and costs contained within documentation submitted to the department for reimbursement from the fund. Therefore, the tank owner and/or operator or petroleum site owner, and his/her representative or Corrective Action Contractor, shall produce any records, data, documents, information and personnel for interviews as necessary in the Commissioner's determination to fully and completely conduct an audit.
- (12) Applications for Payment.
- (a) Applications for reimbursement for costs of corrective actions shall be submitted on a form established by the division which shall include an itemization of all charges according to labor hours and rates, analytical charges, equipment charges, and other categories which may be identified by the division, or which the applicant may wish to provide.
 - (b) The following statement shall be signed in accordance with the requirements of either part 1 or 2 of this subparagraph:

I certify to the best of my knowledge and belief: that the costs presented therein represent actual costs incurred in the performance of response actions at this site during the period of time indicated on this application; that an accidental release has occurred from a petroleum underground storage tank system at this site; and that no charges are presented as part of this application that do not directly relate to the performance of corrective actions related to the release of petroleum at this site.

 - 1. The owner or operator or petroleum site owner and the approved corrective action contractor (CAC) or an authorized representative of the approved CAC shall sign the application for payment containing the statement in this subparagraph if authorized payments from the fund will be made in accordance with the provisions of subparagraph (14)(a) of this rule.
 - 2. The owner or operator or petroleum site owner shall sign the application for payment containing the statement in this subparagraph if authorized payments from the fund will be made in accordance with the provisions of subparagraph (14)(b) of this rule.
 - (c) Applications for payments may be submitted following acceptance by the division of completed corrective actions. Such corrective actions may include but are not limited to the following:
 - 1. Completion of hazard management activities, which were authorized by the division, including, but not limited to, provision of an alternate water supply;

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2. Completion and submittal of a Hazard Management Report;
 3. Development and submittal of an Initial Site Characterization Report;
 4. Development and submittal of a Risk Analysis Report;
 5. Implementation of interim remediation and/or risk management activities, which were authorized by the division;
 6. Advanced risk-based modeling development, which was authorized by the division; and/or
 7. Development and/or implementation of a corrective action plan, which was authorized by the division.
- (d) Applications for payments for the implementation of corrective action may be submitted sixty (60) days following initiation of work to implement the Corrective Action Plan and at sixty (60) day intervals thereafter until completion of the authorized activities. Upon request, the division may approve interim payments at more frequent intervals.
- (e) All payments shall be subject to approval by the division. Should a site inspection or other information available to the division reveal a discrepancy between the work performed and the work addressed by a payment application, the division may deny payment or may require the fund to be reimbursed.
- (f) All applications for payment of costs of cleanup shall be received by the division within one (1) year of performance of the task or tasks covered by that application in order to be eligible for payment from the fund.
- (g) Except for the situations provided for in subparagraph (10)(a) of this rule, payment shall not be made for corrective actions performed at a site until the division has reviewed and accepted a cost proposal for that work and until funds have been obligated from the fund for completion of that particular stage of work.
- (h) For payment of third party claims, the UST owner or operator or petroleum site owner shall submit an application to the division, using the approved form, attaching the original or a certified copy of a final judgment (enforceable in Tennessee) with proof of payment of the applicable financial responsibility requirement for compensation of third parties as specified in subparagraph (6)(b) of this rule. The UST owner or operator or petroleum site owner shall submit proof that a motion was submitted to the court on their behalf requesting that the type and amounts of all damages awarded to the third party(ies) in the final judgment be specifically listed. This application shall be received by the division no later than thirty (30) days after notification of judgment.
1. The division may require additional information to determine the eligibility of a cost for payment.
 2. If the application is determined to be incomplete, the division shall notify the applicant of the deficiencies. The applicant shall submit supplemental information to correct the deficiencies within forty-five (45) days of receipt

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of notice. The applicant may submit a written request for an extension of time for submittal of information to the division. The applicant shall state and the division shall approve the conditions which warrant an extension of submittal time.

3. Only the following costs shall be eligible for payment or reimbursement from the fund:
 - (i) Awards for property damage to third parties made by a court of suitable jurisdiction in Tennessee; and
 - (ii) Awards for bodily injury to third parties made by a court of suitable jurisdiction in Tennessee.

(13) Settlement of Third Party Claims.

- (a) No settlement of a third party claim shall be made by an owner or operator or petroleum site owner without the prior approval of the division. The fund shall not be obligated to pay any claim for reimbursement if the owner or operator or petroleum site owner enters into a settlement without the prior approval of the division.
- (b) The fund shall not be obligated to pay any final and enforceable third party judgment or reimburse an owner or operator or petroleum site owner for payment of the judgment in any amount exceeding a settlement offer rejected by the owner or operator or petroleum site owner which was submitted to the division, reviewed and approved by the division for payment.

(14) Fund Payment Procedures.

- (a) Where the owner or operator or petroleum site owner has submitted an acceptable application for payment for corrective actions or third party claims but has not paid for these activities or claims, payments will be made by a check written to both the eligible owner or operator or petroleum site owner and the provider of the corrective action services or third party.
- (b) Payments from the fund will be made directly to the eligible owner or operator or petroleum site owner in cases where the owner or operator or petroleum site owner submits documentation verifying the owner or operator or petroleum site owner has paid in excess of the applicable financial responsibility requirement for taking corrective actions as specified in subparagraph (7)(b) of this rule.
- (c) The owner or operator or petroleum site owner is responsible for final payment to the contractor who performed the corrective actions and for payment of judgments to third parties.
- (d) Contingent upon availability of funds, the Department shall process all applications for payment as soon as possible upon receipt of application. If all costs are considered to be reasonable and eligible for reimbursement, payment will be issued within ninety (90) days once costs have been determined to be reasonable and eligible for reimbursement. If certain costs are considered as not being reasonable or eligible for reimbursement, the division may issue a check for the amount of the application not in question and provide a forty-five (45) day period in which the owner or operator or petroleum site owner or contractor may present such information as is necessary

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to justify the disallowed costs. Following review of such information, the division may agree to pay the previously disallowed costs, or any portion thereof, or may again disallow the costs for payment. If the division disallows costs upon a second review, the owner and/or operator or petroleum site owner may petition the Board for a hearing on the disallowance pursuant to rule 1200-1-15-.11.

(15) Approval of Corrective Action Contractors.

- (a) The Corrective Action Contractor ("CAC") is the person responsible for conducting and overseeing the corrective action at a petroleum underground storage tank site. There shall be only one CAC for each site.

1. The CAC shall be either:

- (i) A properly licensed contractor, licensed engineer, registered geologist, or other licensed environmental professional; or
- (ii) An owner or operator of the petroleum underground storage tank(s) which caused the release of petroleum to the environment or petroleum site owner, provided that each contractor/subcontractor working for the owner or operator or petroleum site owner shall be a properly licensed contractor pursuant to T.C.A. §62-6-101 et seq.

- (b) CACs will be approved to perform fund eligible work upon satisfaction of the following:

1. The CAC files a written application to become an Approved Corrective Action Contractor with the division via certified mail or personal service. This application shall be updated by April 1 of each year and include name of CAC, principal(s) of CAC, address(es) of CAC's office, office phone number(s) of CAC, and other information requested by the division of Underground Storage Tanks.

2. The CAC submits a sworn statement with the written application in part 1., including the following provisions:

- (i) The CAC will abide by and comply with the Rules and Regulations of the Department of Finance and Administration, Chapter 0620-3-3, Personal Services and Consultant Services Contracts. The CAC will abide by Rule 0620-3-3-.03(f)(g)(h)(i)(l)(m), Rule 0620-3-3-.04(a)(b)1,5,6; Rule 0620-3-3-.04(c)2; and Rule 0620-3-3.06(a)(b)(c)(d)(e)(g)(h)(l)(m).
- (ii) The CAC will have written contract(s) with all contractors/subcontractors, and contract(s) shall contain provisions that contractors/subcontractors will abide by and comply with the Rules and Regulations of the Department of Finance and Administration, Chapter 0620-3-3, Rule 0620-3-3-.03(f)(g)(h)(i)(l)(m), Rule 0620-3-3.04(a)(b)1,5,6; Rule 0620-3-3-.04(c)2; and Rule 0620-3-3.06(a)(b)(c)(d)(e)(g)(h)(l)(m), Personal Services and Consulting Services Contracts. Contract(s) between the CAC and contractors/subcontractors shall also contain provisions that all site workers

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working under authority of contractors/subcontractors shall have applicable health and safety training when required by the Tennessee Department of Labor;

- (iii) Site workers working under authority of the CAC will have the applicable health and safety training when required by the Tennessee Department of Labor;
- (iv) The CAC understands that reimbursement from the fund will be in accordance with the reasonable rate schedule as established by the division;
- (v) If the CAC is not the owner or operator of the tank that caused the release or petroleum site owner, the CAC will have a written contract with the UST owner and/or operator or petroleum site owner, and the contract shall contain the following sentence conspicuously located on the first page of the contract:

The Corrective Action Contractor will/will not (mark one) use the division's reasonable rate schedule when invoicing the owner or operator or petroleum site owner for the expenses incurred in the investigation and cleanup of this site.

- (vi) If the CAC is the owner or operator of the tank which caused the release or petroleum site owner, the CAC will have a written contract with all contractors/subcontractors, and the contract shall contain the following sentence conspicuously located on the first page of the contract:

The contractor/subcontractor (mark one) will/will not (mark one) use the division's reasonable rate schedule when invoicing the owner or operator or petroleum site owner for the expenses incurred in the investigation and cleanup of this site;

- (vii) The CACs services will be performed in a manner consistent with the level of care and skill ordinarily exercised by members of their profession practicing in the State of Tennessee, under similar conditions, and at the time the services were rendered. The CAC shall not knowingly or willfully cause the spread of contamination nor inhibit corrective action at the site;
- (viii) The CAC will gather and maintain documentation and records necessary for filing a claim with the Tennessee Petroleum Underground Storage Tank Fund;
- (ix) The CAC will, at a minimum, follow Quality Assurance/Quality Control Standard Operating Procedures supplied by the division, unless alternate Quality Assurance/Quality Control is approved in writing in advance by the division;
- (x) The CAC will assure that the CAC and/or any person the CAC employs or contracts with to engage in the practice of engineering

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shall be appropriately licensed/registered under the Tennessee Architects, Engineers, Landscape Architects and Interior Designers Law and Rules T.C.A. §62-2-101 et seq.;

- (xi) The CAC will assure that any and all work defined as contracting in Tennessee Contractor's License Law (T.C.A. §62-6-101 et seq.) shall be performed by a licensed contractor(s) with appropriate classification and monetary limitation;
 - (xii) The CAC will assure that the CAC and/or any person the CAC employs or contracts with to perform professional geologic work shall be appropriately registered under the Tennessee Geologists Act (T.C.A. §62-36-101 et seq.); and
 - (xiii) The CAC will assure that all work done by the CAC had the prior approval of a Registered Professional Engineer or Professional Geologist who is licensed/registered with the Tennessee Department of Commerce and Insurance, and the work was done as specified in chapter 1200-1-15 and/or according to a plan approved by the division. The CAC will assure that all plans and reports submitted to the division were prepared and signed by the Registered Professional Engineer or Professional Geologist who prepared or is responsible for the plan or report. The CAC will further assure that a Registered Professional Engineer or Professional Geologist shall make periodic site visits to verify whether or not the work performed was as specified by the Registered Professional Engineer or Professional Geologist, and as specified in chapter 1200-1-15, and/or according to a plan approved by the division. The CAC shall require a Registered Professional Engineer or Professional Geologist to submit a signed certification based on their personal observation and review of job site records stating whether or not the work was performed as directed by the Registered Professional Engineer or Professional Geologist, and whether or not the work has been performed in accordance with chapter 1200-1-15, and/or a plan approved by the division. If the work was not performed according to the above specifications, the certification shall include a listing of how the work which was performed varies from chapter 1200-1-15, the approved plan, and/or the authorization of the Registered Professional Engineer or Professional Geologist and the specific reason for each variation. The certification shall be submitted according to a schedule and format determined by the division.
 - (xiv) The CAC will fully and completely cooperate with the Commissioner during any audit by the Commissioner or his authorized representative, and comply with subparagraph (11)(f) of this rule.
3. The CAC has any applicable license(s) and registration(s) required in the State of Tennessee; and
- (i) If the CAC is a licensed contractor, the contractor shall be properly licensed with an S-Underground Tank Installers, Removal, and

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Remediation of Pollutants or other applicable classification with a monetary limitation as required under Rule 0680-1-.13 and established by the Board for Licensing Contractors of the Tennessee Department of Commerce and Insurance in the amount of at least three hundred fifty thousand dollars (\$350,000). Date of license expiration shall be included. The CAC shall submit requirements of this part with the application required in part 1 and shall submit documentation of any changes, renewals, renovations, etc. of the CAC's Tennessee license. (There shall be no fund reimbursement for those expenses which exceed the contractor's monetary limitation.)

- (ii) All contractors and their subcontractors and employees shall have other applicable license(s) and registration(s).

- 4. The CAC shall maintain liability insurance coverage of the types and in the amounts described in the Table below, or the equivalent, and shall provide certification, with the division listed as a certificate holder, to the division of such coverage with the application described in part 1. and on April 1 of each year thereafter, or more frequently if necessary to keep the division updated as to the CAC's current insurance coverage.

<u>Type of Policy</u>	<u>Limits of Liability</u>	<u>Description</u>
Worker's Compensation	Statutory	All states
Employer's Liability	\$500,000	
Automobile Liability	\$1,000,000 combined single limit (bodily injury and property damages)	All owned, non-owned, and hired vehicles
General Liability	\$1,000,000 combined single limit	Broad Form Comprehensive General Liability

- 5. The CAC will submit a list of the CAC's employees which will be utilized by the CAC as a part of the assessment and remediation of UST sites in the State of Tennessee. This list shall include each employee's job description, title, office, location, and telephone number. This information shall be submitted with the application described in part 1 and annually with a due date of April 1 of each year thereafter.

- (c) The Department will provide notice that applications are to be requested by publication of a legal advertisement which will provide interested firms with the information necessary to request instructions for preparation and submittal of applications and supporting documentation. Prior to the development of an Approved Corrective Action Contractors list, the Department will contact consulting firms listed on the unendorsed list titled "Professional Consulting Firms - Engineers and Geologists" to notify consulting firms of the requirements of subparagraph (b) of this paragraph. Applications received within forty-five (45) days of the date of legal advertisement shall be reviewed prior to establishing a list of Approved Corrective Action Contractors. Applications and supporting documentation shall be independently evaluated by members of a review committee consisting of Division of Underground Storage Tanks staff members according to criteria of subparagraph (b) of this paragraph. Those CACs satisfactorily meeting the requirements of parts (b)1 through 5 of this paragraph shall be placed on the Department's list of UST Approved Corrective Action Contractors. Once a CAC has been approved, they will

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not be required to requalify except under the provisions of subparagraphs (d), (f), and (h) of this paragraph.

1. Applications received after forty-five (45) days from the date of the legal advertisement shall not be reviewed until a list of Approved Corrective Action Contractors is established. These and subsequent applications shall be reviewed by the review committee and either added to the list of Approved CACs or denied Approved CAC status within ninety (90) days of receipt of the completed application with supporting documentation, or establishment of the Approved CAC list, whichever is later;
2. If the review committee does not approve a CAC and does not place the CAC on the list of Approved CACs, the decision of the review committee may be appealed to the Board;
3. CACs who previously submitted applications but did not meet requirements of parts (b)1 through 5 of this paragraph may submit a subsequent application for review at such time they feel that the requirements of (b)1 through 5 of this paragraph may have been met.

(d) At any time other than when the division compiles the new year's Approved CAC list after the submission of information each April 1, a CAC will be removed from the division's Approved CAC list when it has been determined that the CAC has failed to satisfactorily maintain the requirements of subparagraph (b) of this paragraph or has committed one or more of the violations listed in subparagraph (e) of this paragraph.

1. The removal process shall be initiated when a complaint is referred to the division's review committee;
2. The review committee shall inform the CAC via certified mail of receipt of a complaint;
3. The division's review committee may request the CAC to appear at a meeting to show cause why the Department should not remove the CAC from the list of Approved CACs;
4. The CAC may request a meeting with the review committee;
5. The review committee shall notify the CAC of its decision via certified mail within sixty (60) days of dispatch of the certified letter referenced in part 2 of this subparagraph;
6. If the review committee decides to remove the CAC from the list of Approved CACs, removal shall be effective thirty (30) days after dispatch to the last known address on file with the division unless:
 - (i) the CAC corrects the non-compliance to the satisfaction of the review committee during the thirty (30) day period; or
 - (ii) the CAC files a written appeal with the division within the thirty (30) day period requesting a hearing to appeal the decision of the review committee to the Board.

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7. If the division removes a CAC from the list of Approved CAC's the CAC may petition the Board for a hearing on its removal pursuant to rule 1200-1-15-.11. The filing of an appeal will postpone actions to remove a CAC from the list of Approved CACs until the appeal is heard by the Board;
 8. Once the review committee has dispatched a Notice of Removal to a CAC via certified mail, the division will approve no additional plans, scopes of work, or cost proposals if such approval will cause division personnel to violate T.C.A. §62-6-120(c)(1);
 9. If an appeal is not filed during the sixty (60) day period, the decision of the review committee will be final;
 10. A CAC removed from the Approved CAC list may reapply for approval as provided for in subparts (i) or (ii) of this part:
 - (i) A CAC who was removed from the Approved CAC list due to failure to satisfactorily maintain the requirements of subparagraph (b) of this paragraph may reapply under subparagraphs (b) and (c) of this paragraph once the requirements of subparagraph (b) of this paragraph have been met;
 - (ii) A CAC who was removed from the Approved CAC list due to one or more of the violations listed in (e) below may reapply after one (1) year. The CAC shall submit evidence showing the reasons why the CAC should be reinstated for evaluation by the review committee. The CAC shall reapply under the provisions of subparagraphs (15)(b) and (c) of this rule.
- (e) A CAC may be removed from the list of approved Corrective Action Contractors if it is determined by a review committee consisting of division staff members that the CAC has done any of the following:
1. The CAC charged the state or owner/operator for unnecessary or unapproved work or work which was not performed;
 2. The CAC filed false information with the Department;
 3. The CAC has been found guilty of violating any of the following or a comparable law in another jurisdiction:
 - (i) T.C.A. §39-16-503 Tampering with or fabricating evidence;
 - (ii) T.C.A. §39-16-504 Destruction of and tampering with governmental records;
 - (iii) T.C.A. §39-14-130 Destruction of valuable papers with intent to defraud;
 - (iv) T.C.A. §39-14-114 Forgery;
 - (v) T.C.A. §39-14-104 Theft of services, or

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- (vi) T.C.A. §39-14-103 Theft of property;
 - (vii) T.C.A. §68-211-101 et seq. Solid Waste Disposal Act;
 - (viii) T.C.A. §68-212-101 et seq. Hazardous Waste Management Act;
 - (ix) T.C.A. §69-3-101 et seq. Water Quality Control Act;
 - (x) Other environmental regulatory legislation.
4. The CACs or an employee(s), principal(s), or officer(s) of the CAC is found to have engaged in the unauthorized practice of engineering, contracting, or geology under T.C.A. §62-2-101 et seq., §62-6-101 et seq., and §62-36-101 et seq., or a comparable law in another jurisdiction by the appropriate regulatory agency or court.
5. Due to the quality of work performed by the CAC, the CAC has significantly delayed or inhibited progress in achieving appropriate corrective action at a site(s). This shall include, but shall not be limited to, the following:
- (i) The CAC performs a non-approved action which spreads contamination in the environment;
 - (ii) The CAC files a plan (e.g. Environmental Assessment Plan, Corrective Action Plan, etc.) which is rejected by the division as deficient, followed by three subsequent revisions, each of which is rejected by the division as deficient; or
 - (iii) The CAC fails to supply recommendations for further assessment, remediation, site specific cleanup standards, site closure, or other conclusions supported by the following:
 - (I) The physical and chemical characteristics of petroleum, including its toxicity, persistence, and potential for migration;
 - (II) The hydrogeologic characteristics of the petroleum site and the surrounding land;
 - (III) The proximity, quality, and current and future uses of groundwater;
 - (IV) An exposure assessment;
 - (V) The proximity, quality, and current and future uses of surface waters;
 - (VI) Applicable regulations in chapter 1200-1-15; and

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- (VII) The magnitude and extent of petroleum contamination at the petroleum site and the surrounding land.
 - (iv) The CAC supplies recommendations for further assessment, remediation, site specific cleanup standards, site closure, or other conclusions not supported by items (I) through (VII) listed in subpart (iii) of this part.
 - 6. The CAC filed plan(s) or report(s) which do not bear the appropriate signature and Tennessee license/registration number of a Registered Professional Engineer or Professional Geologist.
 - 7. The CAC performed work which did not have the prior approval of a Registered Professional Engineer or Professional Geologist who is licensed/registered with the Tennessee Department of Commerce and Insurance.
 - 8. The CAC has deviated from an approved plan or scope of work without the approval of the division. This includes, but is not limited to, the following:
 - (i) Failure to follow Quality Assurance and Quality Control approved in the plan, or
 - (ii) Failure to follow the schedule for implementation approved in the plan.
 - 9. The CAC has failed to follow Quality Assurance/Quality Control (QA/QC) procedures supplied by the division without having alternate QA/QC approved in advance in writing by the division.
 - 10. The CAC has failed to follow UST regulations promulgated in chapter 1200-1-15.
 - 11. The CAC failed to have a Registered Professional Engineer or Professional Geologist file a signed certification according to a schedule and format required by the division. Said certification shall be based on the Registered Professional Engineer's or Professional Geologist's personal observation and review of job site records. The certification shall state whether or not the work was performed as directed by a Registered Professional Engineer or Professional Geologist, and whether or not the work has been performed in accordance with chapter 1200-1-15, and/or a plan approved by the division. The certification shall include a listing of how the work performed varies from chapter 1200-1-15, the approved plan, and/or the work approved of the Registered Professional Engineer or Professional Geologist and the specific reason for each variation.
- (f) A CAC that fails to comply with the requirements of parts (b) 1, 4, or 5 of this paragraph on April 1 of any year will not be eligible to remain on the list of approved contractors.
- 1. The review committee shall inform the CAC via certified mail that removal shall be seven (7) days after dispatch to the last known address on file with the division unless the CAC corrects the non-compliance to the satisfaction of the review committee during the seven (7) day period.

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2. A CAC that fails to correct this noncompliance as provided in part 1 of this subparagraph, may reapply to be on the Approved CAC list under subparagraphs (b) and (c) of this rule once it can meet all of those requirements.
 - (g) No CAC shall be placed on the Approved Corrective Action Contractors list if the CAC is on a list of contractors banned from usage on federally funded projects. If a CAC on the Approved Corrective Action Contractors list is placed on the list of contractors banned from usage on federally funded projects, that CAC will be removed from the Approved Corrective Action Contractors list. When the CAC is removed from the list of contractors banned from usage on federally funded projects, the CAC may apply to be added to the Approved Corrective Action Contractors list according to procedures outlined in subparagraphs (b) and (c) of this paragraph. A CAC on a list of contractors banned from usage on federally funded projects cannot work as a subcontractor to an Approved Corrective Action Contractor.
 - (h) The appearance of a CAC on the division's list of Approved Corrective Action Contractors shall in no way establish liability or responsibility on the part of the division, the fund, or the State of Tennessee in regards to the services provided by the CAC or circumstances which may occur as a result of such services.
 - (i) An owner or operator may perform corrective actions for releases of petroleum from USTs he owns or operates provided that he submits an application with documentation as described in subparagraphs (b) and (c) of this paragraph and the application is approved by the division. The owner or operator may use qualifications of subcontractor(s) in addition to qualifications of the owner or operator in applying for Approved Corrective Action Contractor status. If an owner or operator uses a subcontractor(s) in qualifying for an Approved Corrective Action Contractor classification and there is a change of a subcontractor whose qualifications were used in the application or documentation, then the owner or operator shall notify the division; the owner or operator shall be removed from Approved Corrective Action Contractor status. The owner or operator shall submit a new application with documentation and be approved as discussed in subparagraphs (b) and (c) of this paragraph to continue work as an Approved Corrective Action Contractor.
 - (j) A CAC working as a subcontractor under contract to an Approved CAC is not required to be classified as an Approved CAC. The subcontractor shall maintain all applicable license(s) and/or registration(s) required in the State of Tennessee for work performed.
- (16) Recovery of Costs by State - Apportionment of Liability.
- (a) Making use of any and all appropriate existing state legal remedies, the Commissioner may commence court action to recover the amount expended by the state from any and all responsible parties for each site investigated, identified, contained or cleaned up, including up to the limits of financial responsibility for owners and/or operators of petroleum underground storage tanks covered by the fund and the entire amount from owners and/or operators of petroleum underground storage tanks not covered by the fund.
 - (b) In any action under this rule, no responsible party shall be liable for more than that party's apportioned share of the amount expended by the state for such site. The

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responsible party has the burden of proving his apportioned share. Such apportioned share shall be based solely on the liable party's portion of the total volume of the petroleum at the petroleum site at the time of action under this chapter. Any expenditures required by the provisions of this chapter made by a responsible party (before or after suit) shall be credited toward any such apportioned share.

- (c) In no event shall the total moneys recovered from the responsible party or parties exceed the total expenditure by the state for each site.
- (d) Any party found liable for any costs or expenditures recoverable under this chapter who establishes by a preponderance of evidence that only a portion of such costs or expenditures are attributable to his or her actions shall be required to pay only for such portion.
- (e) If the trier of the fact finds evidence insufficient to establish such party's portion of costs or expenditures in such a cost recovery, the court shall apportion such costs or expenditures among the defendants, to the extent practicable, according to equitable principles.

(17) Failure to Take Proper Action.

Any responsible party who fails without sufficient cause to properly provide for removal of petroleum or remedial action upon order of the commissioner pursuant to this chapter may be liable to the state for a penalty in an amount equal to one hundred fifty percent (150%) of the amount of any costs incurred by the state as a result of such failure to take proper action. The Commissioner may recover this penalty in an action commenced under T.C.A. §68-53-115, paragraph (16) of this rule, or in a separate civil action, and such penalty shall be in addition to any costs recovered from such responsible party pursuant to this chapter.

(18) Severability.

If any paragraph, subparagraph, part, subpart, item or subitem, section or subsection of this Rule is adjudged unconstitutional or invalid by a court of competent jurisdiction, the remainder of this Rule shall not be affected thereby.

Rule 1200-1-15-.10 Fee Collection and Certification Issuance Regulations is amended by deleting it in its entirety and replacing it with the following:

1200-1-15-.10 FEE COLLECTION AND CERTIFICATION ISSUANCE REGULATIONS.

(1) Purpose.

The purpose of this Rule is to establish a system and schedule for collection of underground storage tank fees.

(2) Applicability.

Requirements of this Rule apply to the following persons:

- (a) Owners and/or operators of petroleum underground storage tanks and/or tank compartments required to be reported under the requirements of T.C.A. §68-215-101 et seq., as follows:

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1. All petroleum underground storage tanks and/or tank compartments that are actively storing petroleum;
 2. All petroleum underground storage tanks and/or tank compartments that are reported as in service at the start of the annual billing cycle (July 1 for underground storage tanks and/or tank compartments in East Tennessee, October 1 for underground storage tanks and/or tank compartments in Middle Tennessee, and January 1 for underground storage tanks and/or tank compartments in West Tennessee); and
 3. All petroleum underground storage tanks and/or tank compartments taken temporarily out of service after June 30, 1988, and not properly closed in accordance with rule 1200-1-15-.07(3) through (5).
- (b) Any person electing to pay annual fees on behalf of a tank owner and/or operator, including, but not limited to the owner of the petroleum site.
- (3) Annual Petroleum Underground Storage Tank Fees.
- (a) The required fee shall be submitted in the specified amount, with checks made payable to the Tennessee State Treasurer.
 - (b) Any person who is an owner and/or operator of a petroleum underground storage tank subject to annual fees shall pay the required annual fee unless the fee is paid by another person on behalf of the tank owner or operator.
 - (c) The amount of the annual petroleum underground storage tanks fee shall be either:
 1. Two hundred fifty dollars (\$250) per year for each non-compartmentalized tank; or
 2. Two hundred fifty dollars (\$250) per year per compartment for each compartmentalized tank.
 - (d) The amount of the annual administrative service fee for agencies and functions of the U.S. Government having sovereign immunity shall be either:
 1. Two hundred fifty dollars (\$250) per year for each non-compartmentalized tank; or
 2. Two hundred fifty dollars (\$250) per year per compartment for each compartmentalized tank.
- Agencies and functions of the U.S. Government are not eligible for benefit or financial assistance from the Tennessee Petroleum Underground Storage Tank Fund.
- (e) If an annual fee is paid on an existing underground storage tank which is subsequently permanently closed in accordance with Rule 1200-1-15-.07 and replaced by a new underground storage tank installed at the same site in accordance with Rule 1200-1-15-.02(1) and 1200-1-15-.02(3) no additional annual fee will be required,

RULEMAKING HEARINGS

provided that the replacement tank has the same number of tank compartments as the existing tank. If the replacement tank has more tank compartments than the existing tank, an additional annual fee of two hundred fifty dollars (\$250) per compartment shall be paid. If the replacement tank has fewer tank compartments than the existing tank, no refund of the annual fee or any portion thereof is due, as stated in subparagraph (f) of this paragraph.

- (f) Payment of the entire amount of the annual fee is required for underground storage tanks and/or tank compartments in service or temporarily out of service during any portion of the current billing year. Tanks and/or tank compartments placed into service after the current billing year begins or tanks and/or tank compartments which are permanently closed before the current billing year ends are not due a refund of the annual fee or any portion thereof.

(4) Failure to Pay the Annual Petroleum Underground Storage Tank Fee.

- (a) Any petroleum underground storage tank owner and/or operator of tanks for which the lawfully levied petroleum underground storage tank fee is owed will be assessed a monthly late payment penalty of 5 percent (5%) of the amount owed. Such penalty shall be assessed monthly until the fee and all associated penalties are paid. The tank owner or operator may file with the commissioner a written petition requesting a reduction in the penalties assessed under this subparagraph, setting forth in the petition the grounds and reasons for such a request. At the commissioner's sole discretion, the commissioner may reduce the penalties that otherwise accrue if, in the commissioner's opinion, the failure to pay fees was due to inadvertent error or excusable neglect. However, in no event shall the penalties be reduced to an amount less than ten percent (10%) per annum, plus statutory interest.
- (b) The Division shall not issue a petroleum underground storage tank certificate to any facility where the lawfully levied petroleum underground storage tank fee(s) and/or associated late penalties have not been paid. To refuse or fail to pay the annual fee per tank to the Division is an unlawful action as described in T.C.A. §68-215-104(3).
- (c) The Division shall revoke the petroleum underground storage tank certificate for any facility for which the lawfully levied petroleum underground storage tanks fee(s) and late payment penalties have not been paid. If the annual fee(s) have not been paid, following fifteen (15) days from the receipt of written notice that the Division intends to remove the certificate, a Division representative may remove the certificate from a facility.
- (d) If a lawfully levied fee has not been paid within a reasonable time allowed by the Commissioner, the Commissioner may proceed in the Chancery Court of Davidson County to obtain judgment and seek execution of such judgment against the tank owner and/or operator.

(5) Petroleum Underground Storage Tank Annual Fee Notices.

- (a) Prior to the due date of the annual underground storage tanks fee, the Division shall issue fee notices to the owner and/or operator of the petroleum underground storage tanks. Fee notices and due dates shall be staggered using the three grand divisions of the State of Tennessee.

RULEMAKING HEARINGS

1. Tank fees for underground storage tanks and/or tank compartments in the following East Tennessee counties shall be due on July 31 of each year:

Johnson, Sullivan, Carter, Washington, Unicoi, Hancock, Hawkins, Greene, Claiborne, Grainger, Hamblen, Cocke, Scott, Campbell, Union, Anderson, Knox, Jefferson, Sevier, Morgan, Roane, Loudon, Blount, Bledsoe, Rhea, Meigs, McMinn, Monroe, Grundy, Sequatchie, Hamilton, Bradley, Polk, Franklin, and Marion.
2. Tank fees for underground storage tanks and/or tank compartments in the following Middle Tennessee counties shall be due October 31 of each year:

Stewart, Montgomery, Robertson, Sumner, Macon, Clay, Pickett, Houston, Hickman, Cheatham, Davidson, Wilson, Trousdale, Smith, Jackson, Overton, Fentress, Putnam, Cumberland, White, DeKalb, Van Buren, Warren, Cannon, Rutherford, Williamson, Dickson, Humphreys, Perry, Wayne, Lewis, Lawrence, Maury, Giles, Marshall, Lincoln, Moore, Bedford, and Coffee.
3. Tank fees for underground storage tanks and/or tank compartments in the following West Tennessee counties shall be due January 31 of each year:

Lake, Obion, Weakley, Henry, Dyer, Crockett, Gibson, Carroll, Benton, Lauderdale, Tipton, Shelby, Haywood, Fayette, Madison, Hardeman, Henderson, Chester, McNairy, Decatur, and Hardin.
- (b) The annual fee shall be paid on or before the due date.
- (c) For any underground storage tank system brought into use after the effective date of this rule, the current year's annual fee shall be submitted with the required notice of existence of such tank system required in Rule 1200-1-15-.02(1)(a)2.
- (d) For any underground storage tank system not previously reported to the division, the current year's annual fee shall be submitted with the required notice of existence of such tank system.
- (6) Issuance of Annual Petroleum Underground Storage Tank Facility Certificates.
 - (a) The Division shall issue petroleum underground storage tank facility certificates annually. The certificate will contain the facility identification number, address, number of underground storage tanks, number of tank compartments and the size of said tanks and/or compartments. The color of the certificate will be changed annually in order to assist persons delivering petroleum in determining if the underground storage tank facility has a current certificate.
 - (b) Certificate issuance shall be staggered using the three grand divisions of the State of Tennessee. Certificates shall be issued as follows:
 1. Petroleum underground storage tank facility certificates for East Tennessee shall be issued in the month of September to owner/operators for petroleum underground storage tanks in the following counties:

RULEMAKING HEARINGS

Johnson, Sullivan, Carter, Washington, Unicoi, Hancock, Hawkins, Greene, Claiborne, Grainger, Hamblen, Cocke, Scott, Campbell, Union, Anderson, Knox, Jefferson, Sevier, Morgan, Roane, Loudon, Blount, Bledsoe, Rhea, Meigs, McMinn, Monroe, Grundy, Sequatchie, Hamilton, Bradley, Polk, Franklin, and Marion.

The annual certificate shall be effective for one year, starting October 1 of the year to September 30 of the following year.

2. Petroleum underground storage tank facility certificates for Middle Tennessee shall be issued in the month of December to owner/operators for petroleum underground storage tanks in the following counties:

Stewart, Montgomery, Robertson, Sumner, Macon, Clay, Pickett, Houston, Hickman, Cheatham, Davidson, Wilson, Trousdale, Smith, Jackson, Overton, Fentress, Putnam, Cumberland, White, DeKalb, Van Buren, Warren, Cannon, Rutherford, Williamson, Dickson, Humphreys, Perry, Wayne, Lewis, Lawrence, Maury, Giles, Marshall, Lincoln, Moore, Bedford, and Coffee.

The annual certificate shall be effective for one year, starting January 1 of the year to December 31 of the same year.

3. Petroleum underground storage tank facility certificates for West Tennessee shall be issued in the month of March to owner/operators for petroleum underground storage tanks in the following counties:

Lake, Obion, Weakley, Henry, Dyer, Crockett, Gibson, Carroll, Benton, Lauderdale, Tipton, Shelby, Haywood, Fayette, Madison, Hardeman, Henderson, Chester, McNairy, Decatur, and Hardin.

The annual certificate shall be effective for one year, starting April 1 of the year to March 31 of the following year.

(7) Unlawful Action.

It shall be unlawful to put petroleum into underground storage tanks and/or tank compartments at a facility without a current petroleum underground storage tank facility certificate. This is a violation for the person putting petroleum into the underground storage tank and/or tank compartment as well as for the person having product put into the underground storage tank and/or tank compartment.

(8) Removal of Certificates.

The Division may remove the petroleum underground storage tank facility certificate from a facility if the owner and/or operator violates the provisions of T.C.A. §68-215-101 et seq. or any regulations promulgated subsequent to this Act. Such removal shall be authorized through issuance of a Commissioner's Order due to violations of the Act or regulations. The owner and/or operator may appeal the Commissioner's Order to the Board.

Rule 1200-1-15-.12 Indicia of Ownership is amended by deleting paragraph (2) in its entirety and renumbering the subsequent paragraphs accordingly.

RULEMAKING HEARINGS

The notice of rulemaking set out herein was properly filed in the Department of State on the 27th day of July, 2005. (07-35)

RULEMAKING HEARINGS

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620 BUREAU OF TENNCARE

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Nashville Public Library Auditorium, 1st Floor, 615 Church Street, Nashville, Tennessee 37219 at 9:30 a.m. C.D.T. on the 19th day September 2005.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Department of Finance and Administration, Bureau of TennCare, to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings) to allow time for the Bureau of TennCare to determine how it may reasonably provide such aid or service. Initial contact may be made with the Bureau of TennCare's ADA Coordinator by mail at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6474 or 1-800-342-3145.

For a copy of this notice of rulemaking hearing, contact George Woods at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or call (615) 507-6446.

SUBSTANCE OF PROPOSED RULE

Paragraph (5) of rule 1200-13-13-.08 Providers is deleted in its entirety and replaced with a new paragraph (5) which shall read as follows:

- (5) Providers may seek payment from a TennCare enrollee only under the following circumstances:
 - (a) If the services are not covered by the TennCare program and the provider informed the enrollee the services were not covered prior to providing the services; or
 - (b) If the services are not covered services because they are in excess of an enrollee's established benefit limit. Before a provider can bill an enrollee for a service that is in excess of the enrollee's established benefit limit, he/she must first submit a claim to the appropriate managed care entity and receive a written denial from the managed care entity. The reason for the denial must be that the service exceeds the enrollee's benefit limit. Only when the provider has a written denial of the service because it is in excess of the enrollee's benefit limit may he/she bill the enrollee for that service.

Authority: T.C.A. §§4-5-202, 4-5-203, 71-5-105, 71-5-109, Executive Order No. 23.

The rulemaking set out herein was properly filed in the Department of State on the 29th day of July, 2005. (07-50)

RULEMAKING HEARINGS

DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620 BUREAU OF TENNCARE

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Nashville Public Library Auditorium, 1st Floor, 615 Church Street, Nashville, Tennessee 37219 at 9:30 a.m. C.D.T. on the 19th day September 2005.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Department of Finance and Administration, Bureau of TennCare, to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings) to allow time for the Bureau of TennCare to determine how it may reasonably provide such aid or service. Initial contact may be made with the Bureau of TennCare's ADA Coordinator by mail at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6474 or 1-800-342-3145.

For a copy of this notice of rulemaking hearing, contact George Woods at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or call (615) 507-6446.

SUBSTANCE OF PROPOSED RULE

Paragraph (5) of rule 1200-13-14-.08 Providers is deleted in its entirety and replaced with a new paragraph (5) which shall read as follows:

- (5) Providers may seek payment from a TennCare enrollee only under the following circumstances:
 - (a) If the services are not covered by the TennCare program and the provider informed the enrollee the services were not covered prior to providing the services; or
 - (b) If the services are not covered services because they are in excess of an enrollee's established benefit limit. Before a provider can bill an enrollee for a service that is in excess of the enrollee's established benefit limit, he/she must first submit a claim to the appropriate managed care entity and receive a written denial from the managed care entity. The reason for the denial must be that the service exceeds the enrollee's benefit limit. Only when the provider has a written denial of the service because it is in excess of the enrollee's benefit limit may he/she bill the enrollee for that service.

Authority: T.C.A. §§4-5-202, 4-5-203, 71-5-105, 71-5-109, Executive Order No. 23.

The rulemaking set out herein was properly filed in the Department of State on the 29th day of July, 2005.
(07-49)

RULEMAKING HEARINGS

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620 BUREAU OF TENNCARE

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Nashville Public Library Auditorium, 1st Floor, 615 Church Street, Nashville, Tennessee 37219 at 9:30 a.m. C.D.T. on the 19th day September 2a005.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Department of Finance and Administration, Bureau of TennCare, to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings) to allow time for the Bureau of TennCare to determine how it may reasonably provide such aid or service. Initial contact may be made with the Bureau of TennCare's ADA Coordinator by mail at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6474 or 1-800-342-3145.

For a copy of this notice of rulemaking hearing, contact George Woods at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or call (615) 507-6446.

Substance of Proposed Rules

Subparagraph (d) of paragraph (1) of rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding new parts 3. and 4. which shall read as follows:

3. Notwithstanding the requirements of this subsection, effective August 1, 2005, such pharmacy notice will not be provided if the enrollee does not receive the medication of the type and amount prescribed because the pharmacy services are no longer covered by TennCare, including when an enrollee has exceeded the monthly pharmacy benefit limit.
4. Notwithstanding the requirements of this subsection, effective August 1, 2005, pharmacists will verify TennCare coverage for all prescriptions presented by enrollees through the PBM. If the PBM denies coverage because an enrollee has exceeded the applicable pharmacy benefit limit, the PBM will provide appropriate notice to enrollees on behalf of the TennCare Bureau. This notice will only be provided upon the first denial of coverage of a pharmacy service sought by the enrollee that exceeds the monthly five (5) prescription limit or the monthly two (2) prescription limit on branded drugs.

Subparagraph (g) of paragraph (4) of rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding a new part 6. which shall read as follows:

6. Effective August 1, 2005, notwithstanding the requirements of this subsection, enrollees are not entitled to continuation or reinstatement of services pending an appeal when the service that is the subject of the appeal, even if prescribed, prior authorized and/or initiated or ordered prior to August 1, 2005, was denied because it is no longer covered by TennCare. This includes appeals related to denials of coverage of pharmacy services when the enrollee exceeds the monthly pharmacy benefit limit.

Subparagraph (a) of paragraph (5) of rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding a new part 5. which shall read as follows:

RULEMAKING HEARINGS

5. Effective August 1, 2005, notwithstanding the requirements of this subsection, a three-day supply of the prescribed drug will not be provided to enrollees who present a prescription at a pharmacy and are denied coverage because the services are not covered by TennCare, including when enrollees have exceeded the monthly benefit limit.

Paragraph (5) of rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding new subparagraphs (e) and (f) which shall read as follows:

- (e) The Bureau of TennCare shall establish a tolerance level for early refills of prescriptions. Such established tolerance level may be more stringent for narcotic substances. Notwithstanding the requirements of this subsection, if an enrollee requests a refill of a prescription prior to the tolerance level for early refills established by the Bureau, the pharmacy will deny this request as a service which is non-covered until the applicable tolerance period has lapsed, and will not provide a three-day supply of the prescribed drug or written notice in accordance with (1)(d) above.
- (f) Effective October 1, 2003, when providing a supply of a prescribed drug as required under this subsection, TennCare must only provide coverage of a three-day supply of the prescribed drug.

Paragraph (7) of rule 1200-13-14-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding a new subparagraph (h) which shall read as follows:

- (h) In no circumstance will a directive be issued by the TennCare Solutions Unit or an Administrative Law Judge to provide a service to an enrollee if, when the appeal is resolved, the service is no longer covered by TennCare for the enrollee. A directive also will not be issued by TennCare Solutions Unit if the service cannot reasonably be provided to the enrollee before the date when the service is no longer covered by TennCare for the enrollee and such appeal will proceed to a hearing.

Authority: T.C.A. 4-5-202, 4-5-203, 71-5-105, 71-5-109, Executive Order No. 23.

The notice of rulemaking set out herein was properly filed in the Department of State on the 29th day of July, 2005. (07-48)

RULEMAKING HEARINGS

TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION - 0620 BUREAU OF TENNCARE

There will be a hearing before the Commissioner to consider the promulgation of amendments of rules pursuant to Tennessee Code Annotated, 71-5-105 and 71-5-109. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Nashville Public Library Auditorium, 1st Floor, 615 Church Street, Nashville, Tennessee 37219 at 9:30 a.m. C.D.T. on the 19th day September 2005.

Any individuals with disabilities who wish to participate in these proceedings (to review these filings) should contact the Department of Finance and Administration, Bureau of TennCare, to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings) to allow time for the Bureau of TennCare to determine how it may reasonably provide such aid or service. Initial contact may be made with the Bureau of TennCare's ADA Coordinator by mail at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or by telephone at (615) 507-6474 or 1-800-342-3145.

For a copy of this notice of rulemaking hearing, contact George Woods at the Bureau of TennCare, 310 Great Circle Road, Nashville, Tennessee 37243 or call (615) 507-6446.

SUBSTANCE OF PROPOSED RULES

Subparagraph (d) of paragraph (1) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding new parts 3. and 4. which shall read as follows:

3. Notwithstanding the requirements of this subsection, effective August 1, 2005, such pharmacy notice will not be provided if the enrollee does not receive the medication of the type and amount prescribed because the pharmacy services are no longer covered by TennCare, including when an enrollee has exceeded the monthly pharmacy benefit limit.
4. Notwithstanding the requirements of this subsection, effective August 1, 2005, pharmacists will verify TennCare coverage for all prescriptions presented by enrollees through the PBM. If the PBM denies coverage because an enrollee has exceeded the applicable pharmacy benefit limit, the PBM will provide appropriate notice to enrollees on behalf of the TennCare Bureau. This notice will only be provided upon the first denial of coverage of a pharmacy service sought by the enrollee that exceeds the monthly five (5) prescription limit or the monthly two (2) prescription limit on branded drugs.

Subparagraph (g) of paragraph (4) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding a new part 6. which shall read as follows:

6. Effective August 1, 2005, notwithstanding the requirements of this subsection, enrollees are not entitled to continuation or reinstatement of services pending an appeal when the service that is the subject of the appeal, even if prescribed, prior authorized and/or initiated or ordered prior to August 1, 2005, was denied because it is no longer covered by TennCare. This includes appeals related to denials of coverage of pharmacy services when the enrollee exceeds the monthly pharmacy benefit limit.

Subparagraph (a) of paragraph (5) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding a new part 5. which shall read as follows:

RULEMAKING HEARINGS

5. Effective August 1, 2005, notwithstanding the requirements of this subsection, a three-day supply of the prescribed drug will not be provided to enrollees who present a prescription at a pharmacy and are denied coverage because the services are not covered by TennCare, including when enrollees have exceeded the monthly benefit limit.

Paragraph (5) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding new subparagraphs (e) and (f) which shall read as follows:

- (e) The Bureau of TennCare shall establish a tolerance level for early refills of prescriptions. Such established tolerance level may be more stringent for narcotic substances. Notwithstanding the requirements of this subsection, if an enrollee requests a refill of a prescription prior to the tolerance level for early refills established by the Bureau, the pharmacy will deny this request as a service which is non-covered until the applicable tolerance period has lapsed, and will not provide a three-day supply of the prescribed drug or written notice in accordance with (1)(d) above.
- (f) Effective October 1, 2003, when providing a supply of a prescribed drug as required under this subsection, TennCare must only provide coverage of a three-day supply of the prescribed drug.

Paragraph (7) of rule 1200-13-13-.11 Appeal of Adverse Actions Affecting TennCare Services or Benefits is amended by adding a new subparagraph (h) which shall read as follows:

- (h) In no circumstance will a directive be issued by the TennCare Solutions Unit or an Administrative Law Judge to provide a service to an enrollee if, when the appeal is resolved, the service is no longer covered by TennCare for the enrollee. A directive also will not be issued by TennCare Solutions Unit if the service cannot reasonably be provided to the enrollee before the date when the service is no longer covered by TennCare for the enrollee and such appeal will proceed to a hearing.

Authority: T.C.A. 4-5-202, 4-5-203, 71-5-105, 71-5-109, Executive Order No. 23.

The notice of rulemaking set out herein was properly filed in the Department of State on the 29th day of July, 2005. (07-47)

RULEMAKING HEARINGS

DEPARTMENT OF HEALTH - 1200 TENNESSEE MEDICAL LABORATORY BOARD DIVISION OF HEALTH RELATED BOARDS

There will be a hearing before the Tennessee Medical Laboratory Board to consider the promulgation of amendments to rules and new rules pursuant to T.C.A. §§ 4-5-202, 4-5-204, 63-1-138, 68-29-103, 68-29-105, 68-29-110, 68-29-116, 68-29-117, 68-29-126, 68-29-127, 68-29-129, and Public Chapters 234, 467 and 479 of the Public Acts of 2005. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Jackson Room of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 2:30 p.m. (CDT) on the 29th day of September, 2005.

Any individuals with disabilities who wish to participate in these proceedings (review these filings) should contact the Department of Health, Division of Health Related Boards to discuss any auxiliary aids or services needed to facilitate such participation or review. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date such party intends to review such filings), to allow time for the Division to determine how it may reasonably provide such aid or service. Initial contact may be made with the ADA Coordinator at the Division of Health Related Boards, First Floor, Cordell Hull Building, 425 Fifth Avenue North, Nashville, TN 37247-1010, (615) 532-4397.

For a copy of the entire text of this notice of rulemaking hearing contact:

Jerry Kosten, Regulations Manager, Division of Health Related Boards, 425 Fifth Avenue North, First Floor, Cordell Hull Building, Nashville, TN 37247-1010, (615) 532-4397.

SUBSTANCE OF PROPOSED RULES

AMENDMENTS

1200-6-1-.03 Necessity of Licensure, is amended by adding the following language as new paragraph (3):

- (3) Use of Titles - Any person who possesses a valid, unsuspended and unrevoked license issued by the Board has the right to use the title or acronym that represents being a medical laboratory director (Ph.D), medical technologist (M.T.), medical laboratory technician (M.L.T.), special analyst (S.A.), or cytotechnologist (C.T.) as defined in T.C.A. §§ 68-29-103. Violation of this rule regarding use of titles shall constitute unethical conduct and subject the licensee to disciplinary action.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-29-103, 68-29-105, 68-29-116, 68-29-127, and Public Chapter 467 of the Public Acts of 2005.

Rule 1200-6-1-.13 Temporary License, is amended by deleting paragraph (4) in its entirety and substituting instead the following language, and is further amended by deleting paragraphs (5), (6), and (7) in their entirety and substituting instead the following language, so that as amended, the new paragraph (4) shall read:

- (4) The validity and duration of temporary licenses shall be governed by T.C.A. § 68-29-117 (d).

Authority: T.C.A. §§ 4-5-202, 4-5-204, 68-29-105, 68-29-117, and Public Chapter 479 of the Public Acts of 2005.

RULEMAKING HEARINGS

1200-6-1-.19 Board Meetings, Officers, Consultants, and Declaratory Orders, is amended by deleting the catchline in its entirety and substituting instead the following language, and is further amended by adding the following language as new paragraphs (6) and (7), so that as amended, the new catchline and the new paragraphs (6) and (7) shall read:

1200-6-1-.19 BOARD MEETINGS, OFFICERS, CONSULTANTS, DECLARATORY ORDERS, AND SCREENING PANELS.

- (6) Screening Panels - The Board adopts, as if fully set out herein, rule 1200-10-1-.13, of the Division of Health Related Boards and as it may from time to time be amended, as its rule governing the screening panel process.
- (7) The board authorizes the member who chaired the board for any contested case to be the agency member to make the decisions authorized pursuant to rule 1360-4-1-.18 regarding petitions for reconsiderations and stays

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-1-138, 68-29-105, 68-29-127, and Public Chapter 234 of the Public Acts of 2005.

Rule 1200-6-3-.05 Licensure Discipline, Civil Penalties, Assessment of Costs, and Subpoenas, is amended by deleting the catchline in its entirety and substituting instead the following language, and is further amended by adding the following language as new paragraph (8), so that as amended, the new catchline and the new paragraph (8) shall read:

1200-6-3-.05 LICENSURE DISCIPLINE, CIVIL PENALTIES, ASSESSMENT OF COSTS, SUBPOENAS, AND SCREENING PANELS.

- (8) Screening Panels - The Board adopts, as if fully set out herein, rule 1200-10-1-.13, of the Division of Health Related Boards and as it may from time to time be amended, as its rule governing the screening panel process.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-1-138, 68-29-105, 68-29-126, and Public Chapter 234 of the Public Acts of 2005.

NEW RULES

TABLE OF CONTENTS

1200-6-2-.08 Advertising

1200-6-3-.20 Advertising

1200-6-2-.08 ADVERTISING.

- (1) Policy Statement. The lack of sophistication on the part of many of the public concerning medical laboratory personnel training programs, the importance of the interests affected by the choosing of a medical laboratory personnel training program and the foreseeable consequences of unrestricted advertising by medical laboratory personnel training programs which is recognized to pose special possibilities for deception, require that special care be taken by medical laboratory personnel

RULEMAKING HEARINGS

training programs to avoid misleading the public. Medical laboratory personnel training programs must be mindful that the benefits of advertising depend upon its reliability and accuracy. Since advertising by medical laboratory personnel training programs is calculated and not spontaneous, reasonable regulation designed to foster compliance with appropriate standards serves the public interest without impeding the flow of useful, meaningful, and relevant information to the public.

(2) Definitions

- (a) Advertisement. Informational communication to the public in any manner designed to attract public attention to medical laboratory personnel training programs that are approved to educate in Tennessee.
- (b) Licensee - Any medical laboratory personnel training programs holding a Certificate of Approval to educate in the State of Tennessee. Where applicable this shall include partnerships and/or corporations.
- (c) Material Fact - Any fact which an ordinary reasonable and prudent person would need to know or rely upon in order to make an informed decision concerning the choice of medical laboratory personnel training programs to serve his or her particular needs.

(3) Advertising Tuition Fees and Services

- (a) Fixed Tuition Fees - Fixed tuition fees may be advertised.
- (b) Discount Tuition Fees. Discount tuition fees may be advertised if:
 - 1. The discount tuition fee is in fact lower than the licensee's customary or usual tuition fee; and
 - 2. The licensee provides the same quality and components of education at the discounted tuition fee that are normally provided at the regular, non-discounted tuition fee.
- (c) Related Services and Additional Fees. Related services which may be required in conjunction with the advertised services for which additional fees will be charged must be identified as such in any advertisement.
- (d) Time Period of Advertised Fees.
 - 1. Advertised fees shall be honored for those seeking the advertised services during the entire time period stated in the advertisement whether or not the services are actually rendered or completed within that time.
 - 2. If no time period is stated in the advertisement of fees, the advertised fee shall be honored for thirty (30) days from the last date of publication or until the next scheduled publication whichever is later whether or not the services are actually rendered or completed within that time.

(4) Advertising Content. The following acts or omissions in the context of advertisement by any licensee shall constitute unethical conduct, and subject the licensee to disciplinary action pursuant to T.C.A. §68-29-127(9).

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- (a) Claims that the education offered is professionally superior to that which is ordinarily offered, or that convey the message that one licensee is better than another when superiority of services, personnel, materials or equipment cannot be substantiated.
- (b) The misleading use of an unearned or non-health degree in any advertisement.
- (c) Promotion of professional services which the licensee knows or should know is beyond the licensee's ability to perform.
- (d) Techniques of communication which intimidate, exert undue pressure or undue influence over a prospective client.
- (e) Any appeals to an individual's anxiety in an excessive or unfair manner.
- (f) The use of any personal testimonial attesting to a quality of competency of a service or treatment offered by a licensee that is not reasonably verifiable.
- (g) Utilization of any statistical data or other information based on past performances for prediction of future services, which creates an unjustified expectation about results that the licensee can achieve.
- (h) The communication of personal identifiable facts, data, or information about a patient without first obtaining patient consent.
- (i) Any misrepresentation of a material fact.
- (j) The knowing suppression, omission or concealment of any material fact or law without which the advertisement would be deceptive or misleading.
- (k) Statements concerning the benefits or other attributes of medical procedures or products that involve significant risks without including:
 - 1. A realistic assessment of the safety and efficiency of those procedures or products; and
 - 2. The availability of alternatives; and
 - 3. Where necessary to avoid deception, descriptions or assessment of the benefits or other attributes of those alternatives.
- (l) Any communication which creates an unjustified expectation concerning the potential results of any treatment.
- (m) Failure to comply with the rules governing advertisement of fees and services, or advertising records.
- (n) The use of "bait and switch" advertisements. Where the circumstances indicate "bait and switch" advertising, the Board may require the licensee to furnish data or other evidence pertaining to those sales at the advertised fee as well other sales.

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- (o) Misrepresentation of a licensee's credentials, training, experience, or ability.
 - (p) Failure to include the corporation, partnership or individual licensee's name, address, and telephone number in any advertisement. Any corporation, partnership or association which advertises by use of a trade name or otherwise fails to list all licensees practicing at a particular location shall:
 - 1. Upon request provide a list of all licensees practicing at that location; and
 - 2. Maintain and conspicuously display at the licensee's office, a directory listing all licensees practicing at that location.
 - (q) Failure to disclose the fact of giving compensation or anything of value to representative of the press, radio, television or other communicative medium in anticipation of or in return for any advertisement (for example, newspaper article) unless the nature, format or medium of such advertisement make the fact of compensation apparent.
 - (r) After thirty (30) days of a personnel departure, the use of the name of any medical laboratory personnel formerly practicing at or associated with any advertised location or on office signs or buildings. This rule shall not apply in the case of a retired or deceased former associate who practiced in association with one or more of the present occupants if the status of the former associate is disclosed in any advertisement or sign.
 - (s) Stating or implying that a certain licensee provides all services when any such services are performed by another licensee.
- (5) Advertising Records and Responsibility
- (a) Each licensee who is a principal partner, or officer of a firm or entity identified in any advertisement, is jointly and severally responsible for the form and content of any advertisement. This provision shall also include any licensed professional employees acting as an agent of such firm or entity.
 - (b) Any and all advertisement are presumed to have been approved by the licensee named therein.
 - (c) A recording of every advertisement communicated by electronic media, and a copy of every advertisement communicated by print media, and a copy of any other form of advertisement shall be retained by the licensee for a period of two (2) years from the last date of broadcast or publication and be made available for review upon request by the Board or its designee.
 - (d) At the time any type of advertisement is placed, the licensee must possess and rely upon information which, when produced, would substantiate the truthfulness of any assertion, omission or representation of material fact set forth in the advertisement or public information.
- (6) Severability. It is hereby declared that the sections, clauses, sentences and part of these rules are severable, are not matters of mutual essential inducement, and any of them shall be rescinded if these rules would otherwise be unconstitutional or ineffective. If any one or more sections, clauses, sentences or parts shall for any reason be questioned in court, and shall be adjudged

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unconstitutional or invalid, such judgment shall not affect, impair or invalidate the remaining provisions thereof, but shall be confined in its operation to the specific provision or provisions so held unconstitutional or invalid, and the in applicability or invalidity of any section, clause, sentence or part in any one or more instance shall not be taken to affect or prejudice in any way its applicability or validity in any other instance.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 68-29-105, 68-29-110, 68-29-129, and Public Chapter 467 of the Public Acts of 2005.*

The notice of rulemaking set out herein was properly filed in the Department of State on the 14th day of July, 2005. (07-15)

RULEMAKING HEARINGS

DEPARTMENT OF HUMAN SERVICES - 1240

ADULT AND FAMILY SERVICES DIVISION

There will be a hearing before the Tennessee Department of Human Services to consider the promulgation repeals of rules and new rules pursuant to Tennessee Code Annotated Sections 4-5-202; 71-1-105(12) and 71-3-502. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place at the following locations:

- (1) Johnson City, Tennessee: September 19, 2005 at 6:30 p.m., Washington County Department of Human Services, 103 East Walnut Street, Conference Room, Johnson City, TN 37601;
- (2) Knoxville, Tennessee: September 20, 2005, 6:30 p.m., Knoxville State Office Building, 7th Floor, 531 Henley Street, Conference Room, A, Knoxville, TN 37902;
- (3) Chattanooga, Tennessee: September 21, 2005, 6:30 p.m., 1st Floor-Auditorium, Chattanooga State Office Building, 540 McCallie Avenue, Chattanooga, TN 37402;
- (4) Cookeville, Tennessee: September 22, 2005, 6:30 p.m. Putnam County Department of Human Services Office, 269 East South Willow, Cookeville, TN 38501;
- (5) Nashville, Tennessee: September 26, 2005, 6:30 p.m., 2nd Floor Board Room, Citizens Plaza State Office Building, 400 Deaderick Street,, Nashville, TN 37248;
- (6) Columbia, Tennessee: September 27, 2005; 6:30 p.m. Suite B, Lobby, Maury County Department of Human Services Office, 1400 College Park Drive, Columbia, TN 38401;
- (7) Jackson, Tennessee: September 28, 2005 6:30 p.m., Suite 210 Lowell Thomas State Office Building, 225 Martin Luther King Jr. Drive, Jackson, TN 38301;
- (8) Memphis, Tennessee: September 29, 2005, 6:30 p.m., Second Floor, Donnelly J. Hill State Office Building, 170 North Main Street, Memphis, TN 38103.

Any individuals with disabilities who wish to participate in these proceedings or to review these filings should contact the Department of Human Services to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date or the date the party intends to review such filings, to allow time for the Department of Human Services to determine how it may reasonably provide such aid or service. Initial contact may be made with the Department of Human Services' ADA Coordinator Fran McKinney at Citizens Plaza Building, 400 Deaderick Street, 3rd Floor, Nashville, Tennessee 37248 and telephone number (615) 313-5563 (TTY)-(800) 270-1349.

For a copy of this Notice of Rulemaking hearing, contact: Valerie Webb, Deputy General Counsel,, Department of Human Services, Citizens Bank Building, 400 Deaderick Street, 15th Floor, Nashville, Tennessee, 37248, telephone number (615) 313-2266.

RULEMAKING HEARINGS

SUBSTANCE OF PROPOSED RULES

CHAPTER 1240-4-3 LICENSURE RULES FOR CHILD CARE CENTERS SERVING PRE-SCHOOL CHILDREN

REPEALS

Chapter 1240-4-3, Licensure Rules for Child Care Centers Serving Pre-School Children, is repealed.

Authority: T.C.A. §§ 4-5-202; 71-1-105(12); and 71-3-502.

NEW RULES

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1240-4-3-.04	Procedures for Obtaining a License	1240-4-3-.13	Transportation
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1240-4-3-.01 SCOPE AND PURPOSE.

- (1) Scope of Rules. These rules are applicable to the licensing of child care centers that care for thirteen (13) or more children, ages six (6) weeks—seventeen (17) years of age for less than twenty-four (24) hours per day as defined by T.C.A. §§ 71-3-501 et seq. Any conflict between this Chapter and any other rules of the Department concerning the licensing procedures and regulations governing child care center standards shall be resolved by reference to these rules.
- (2) Purpose of Licensing. The primary purpose of licensing is the protection of children. These minimum requirements seek to maintain the adequate health, safety, and supervision of children while in a group care setting. The secondary purpose of license is to promote developmentally appropriate child care.

Authority: T.C.A. §§ 4-5-202; 71-1-105(5) and (12); 71-3-501 et seq. 71-3-502(a)(2).

1240-4-3-.02 DEFINITIONS. FOR PURPOSES OF THIS CHAPTER, THE FOLLOWING DEFINITIONS ARE APPLICABLE:

- (1) Administrative Hearing. A fair hearing that is held under the Administrative Procedures Act rather than a court of law. The purpose of the hearing is to allow an agency the opportunity to challenge legal enforcement actions taken by the Department.

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- (2) **Annual License.** An annual permit issued by the Department to a child agency, authorizing the licensee to provide child care in accordance with provisions of the license, the law, and requirements (rules) of the Department. Issuance of a license is not an endorsement of child care methods or of an agency's operational philosophy. A license is not transferable from one location to another or from one licensee/operator to another. All or any part of the license may be revoked at any time upon ninety (90) days notice to the licensee; or if the health, safety, or welfare of the children in care imperatively requires it, may be suspended immediately.
- (3) **Applicant.** The owner or owner's authorized representative who is required, pursuant to the provisions of these rules, to sign the application for a license.
- (4) **Auxiliary staff.** Full and part-time employees of the agency who provide non-caregiving services.
- (5) **Capacity.** The maximum number of children who can be physically located in the child care space at any given point in time. See also, "Licensed Capacity".
- (6) **Caregiver.** An individual, whether paid or unpaid, including the Primary Caregiver, who is responsible for meeting the supervision, protection, and basic needs of the child, and who is used to meet the adult:child ratios required by these rules.
- (7) **C.C.P.** Certified Childcare Professional. An early childhood educational credential granted by the National Child Care Association.
- (8) **C.D.A.** Child Development Associate; an early childhood educational credential granted by the National Council for Professional Recognition.
- (9) **Child or Children.** A person or persons under eighteen (18) years of age.
- (10) **Child Care.** As defined by T.C.A. § 71-3-501, the provision of supervision, protection, and meeting, at a minimum, the basic needs of a child for less than twenty-four (24) hours a day.
- (11) **Child Care Center.** "Child care center" means any place or facility operated by any person or entity that provides child care for three (3) or more hours per day for at least thirteen (13) children who are not related to the primary caregiver; provided, that a child care agency shall not be classified as a "child care center" that operates as a "group child care home" and keeps three (3) additional school-age children as permitted in subdivision (10); provided, further, that all children, related or unrelated shall be counted in the adult-to-child supervision ratios and group sizes applicable to child care centers; with the exception, that if the child care center is operated in the occupied residence of the primary caregiver, children nine (9) years of age or older who are related to the primary caregiver will not be counted in determining the adult-to-child supervision ratios or group sizes applicable to child care centers if such children are provided a separate space from that occupied by the child care center. The department may permit children in the separate space to interact with the children in the licensed child care center in such manner as it may determine is appropriate;
- (12) **Child Care Agency.** "Child care agency" or "agency" means, and only where the context requires in any other provision of law:
 - (a) A place or facility, regardless of whether it is currently licensed, that is operated as a "family child care home", a "group child care home", a "child care center", or a "drop-in center", as those terms are defined in this part; or

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- (b) A place or facility that provides child care for five (5) or more children who are not related to the primary caregiver for three (3) or more hours per day.
- (13) Child Care System. The existence of two (2) or more facilities used for child care purposes which facilities are under the ownership, administration, or control of any individual(s), corporation, partnership, cooperative, or other public or private entity of any kind.
- (14) Commissioner. The executive head of the Department of Human Services, appointed by the Governor.
- (15) Conventional Care. Child care services provided between the hours of 6:00 a.m. and 6:00 p.m., Monday through Friday.
- (16) Day Care. Synonymous with definition of “child care”, above.
- (17) Department (DHS). The Tennessee Department of Human Services and its authorized representatives.
- (18) Developmentally Appropriate. Practices which use a knowledge of child development to identify the range of appropriate behaviors, activities, and materials for a specific age group. This knowledge is used in conjunction with an understanding about individual children’s growth patterns, strengths, interests, and experiences to design the most appropriate learning environment. A developmentally appropriate curriculum provides for all areas of a child’s development, physical, emotional, social, and cognitive, through an integrated approach.
- (19) Director. The on-site manager for the agency who has overall responsibility for the daily oversight of all staff and direct child care services.
- (20) Drop-In Child Care Center. A place or facility operated by any person or entity providing child care, at the same time, for fifteen (15) or more children, who are not related to the primary caregiver, for short periods of time, not to exceed fourteen (14) hours per week and for not more than seven (7) hours per day for any individual child during regular working hours (Monday-Friday 6:00 a.m. to 6:00 p.m.); provided, however, a drop-in center may provide such child care during evenings (after 6:00 p.m.) and weekends (Friday, 6:00 p.m -Sunday, 10:00 p.m.) so long as the drop-in center provides no more than a total of twenty (20) hours per week, exclusive of snow days (defined as days when the school of the affected child is closed); provided, in addition, that drop-in centers may provide such care during snow days; provided, however, that, notwithstanding any other requirements of this part, training requirements for the staff of this class of child care agency shall be limited to basic health and safety precautions and the detection and reporting of child abuse and neglect for children in care; provided, further, that, notwithstanding any other provision of this chapter to the contrary, drop-in centers operated by not-for-profit organizations that provide child care for no more than two (2) hours per day with a maximum of ten (10) hours per week without compensation, while the parent or other custodian is engaged in short-term activities on the premises of the organization, shall register as providing casual care and shall not be deemed to be a drop-in center or regulated as a drop-in center;
- (21) Exemption. A finding by the Department that a program is not required, pursuant to the provisions of T.C.A. § 71-3-503, to be licensed by the Department of Human Services.
- (22) Extended Care. Child care services offered between the hours of 6:00 p.m. and 6:00 a.m. Monday through Friday, and weekend care.

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- (23) **Family Child Care Home.** Any place or facility which is operated by any person or entity that provides child care for three (3) or more hours per day for at least five (5) children but not more than seven (7) children who are not related to the primary caregiver; provided, that the maximum number of children present in the family child care home, including related children of the primary caregiver shall not exceed twelve (12), with the exception that, if the family child care home is operated in the occupied residence of the primary caregiver, children related to the primary caregiver nine (9) years of age or older will not be counted in determining the maximum number of children permitted to be present in a "family child care home" if those children are provided a separate space from that occupied by the family child care home. The department may permit children in the separate space to interact with the children in the licensed family child care home in such manner as it may determine is appropriate;
- (24) **Field Trip.** A trip that is not a part of the regular curriculum of the child care agency and which occurs away from the general premises of the child care agency's licensed facility and beyond reasonable walking distance.
- (a) In order to meet the requirement that the trip not be a part of the regular curriculum, the trip must be an occasional activity that does not represent a regular, ongoing service of the agency.
 - (b) Regularly-scheduled trips (for example, weekly trips) do not meet the definition of a field trip, regardless of whether the regularly-scheduled trips are to different destinations.
- (25) **Foster Home.** A home approved by the Department of Children's Services or a licensed child-placing agency for the residential care of children; any other agency type that may place children with surrogate families is not considered a "Foster Home" for the purposes of these Rules.
- (26) **Group.** A specific number of children comprising a specific age range and assigned to specific staff in an assigned space that is divided from the space of other groups by a recognizable barrier.
- (27) **Group Child Care Home.** Any place or facility operated by any person or entity that provides child care for three (3) or more hours per day for at least eight (8) children who are not related to the primary caregiver; provided, however, that the maximum number of children present in a group child care home, including those related to the primary caregiver, shall not exceed twelve (12) children, with the exception that, if the group child care home is operated in the occupied residence of the primary caregiver, children related to the primary caregiver nine (9) years of age or older will not be counted in determining the maximum number of children permitted to be present in a group child care home, if those children are provided a separate space from that occupied by the group child care home; and, provided, further, that up to three (3) additional school age children, related or unrelated to the primary caregiver, may be received for child care before and after school, on school holidays, on school snow days and during summer vacation. The department may permit children in the separate space to interact with the children in the licensed group child care home in such manner as it may determine is appropriate.
- (28) **Home School.** For the purposes of this rule home schooling is defined as the provision of full-time educational services, as recognized by the Department of Education, to a child by the child's parent or guardian in the child's primary residence.
- (29) **Infant.** A child who is six (6) weeks through fifteen (15) months of age.

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- (30) Law. Statutory or regulatory provisions affecting the operation of a child care agency including, but not limited to, the licensing law as contained in T.C.A. §§ 71-3-501 through 71-3-513, Chapter 1240-4-5, and these rules.
- (31) Licensee. The owner, as defined by these rules, to whom a license to operate a child care facility is issued. The owner or the owner's authorized representative must sign the application for a license.
- (32) Licensed capacity. The designated maximum number of children permitted in a facility as determined by the Department based upon available space, age of children, adult:child ratios, and group size. Licensed capacity shall be designated on the license.
- (33) Operator. The individual who is an owner or administrator of a child care agency or child care system.
- (34) Owner. The individual(s), corporation, partnership, cooperative, or other private or public entity of any kind, or any combination thereof, who or which, through their authorized representatives, assumes, or is legally required to assume, ultimate responsibility for the control of a child care agency.
- (35) Parent. A biological, legal, or adoptive parent, guardian, or legal or physical custodian who has primary responsibility for a child.
- (36) Preschool Child. A general term for any child who is six (6) weeks through five (5) years of age and not in kindergarten, including children who are more specifically defined under this subchapter as an "Infant" or a "Toddler".
- (37) Related. As used in this Chapter, any children of the following relationships by marriage, blood, or adoption: children, step-children, grandchildren, siblings, step-siblings, nieces, and nephews of the primary caregiver. The term related includes any "grand" or "great" relationship (e.g., great niece, great grandchild, etc.) within the relationships indicated.
- (38) School-age Child. A child who is five (5) years of age and enrolled in kindergarten through seventeen (17) years of age. A five (5) year-old may be classified as a school-age child in the summer immediately preceding the child's fall entry into kindergarten.
- (39) Sick Child Care. The provision, for three (3) or more hours per day and less than twenty-four (24) hours per day, of the supervision, protection, and meeting the basic needs of children who have short term illness, symptoms of illness, or who have a medical or technological dependency that requires continuous nursing intervention.
- (40) Staff. Full and part-time caregivers, employees, or unpaid volunteers of the agency.
- (41) Substitute. Paid or unpaid persons who are replacements for regular staff.
- (42) Supervision. For the purposes of this Chapter when children are not within the direct sight and sound of an adult, the term "supervision" includes the following requirements:
 - (a) Children six (6) weeks of age through nine (9) years of age: The adult must be able to hear the child at all times, must be able to see the child with a quick glance, and must be able to physically respond immediately.

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- (b) Exception during mealtime: An adult must be in the direct sight and sound of children ages six (6) weeks through five (5) years, not in kindergarten, while the child is eating.
 - (c) Children ten (10) years of age and older: The adult shall know the whereabouts and activities of the children at all times and must be able to physically respond immediately.
 - (d) Helper devices such as mirrors, electronic sound monitors, etc. may be used as appropriate to meet these requirements.
- (43) Temporary License. A permit issued by the Department to a new child care agency allowing and authorizing the temporary licensee to begin child care operations while the agency attempts to attain full compliance with all other applicable regulations. The temporary license is valid, unless suspended, for one hundred twenty (120) days or until the Department grants or denies the application for an annual license.
- (44) Toddler. A child who is twelve (12) months through thirty (30) months of age.
- (45) Vehicle for Child Care. A vehicle used for transportation of children under the care and supervision of a child care agency is any vehicle that is under the direction or control of the child care agency which is used to provide transportation for children enrolled in the agency, including all vehicles owned or operated by the agency, by a contractor for the agency, or by any other third party providing services to or on behalf of the agency.
- (46) Volunteer. A person who provides services for a child care agency without payment and who is used to supplement the regular staff or substitutes, but who is not used to meet the required adult/child ratios; provided, however, that volunteers can be used to meet the required adult: child ratios at the field trip destination. Volunteers may provide no more than twenty (20) hours of services in any calendar week except during specialized activities or on field trips, as specifically authorized by the Department. Persons who provide services as a volunteer for more than twenty (20) hours per calendar week shall be considered substitutes for all purposes under T.C.A. § 71-3-501 et seq. and this Chapter.
- (47) Youth. A person who is ten (10) years of age through seventeen (17) years of age.

Authority: T.C.A. §§ 4-5-202; 71-1-105(5) and (12); 71-3-501 et seq.; 71-3-502(a)(2).

1240-4-3-.03

BASIS FOR ISSUANCE OF A LICENSE.

- (1) Annual License: All child care agencies are required by Tennessee law to be licensed annually by the Department, unless determined by the Department to be exempt from licensing pursuant to the provisions of T.C.A. § 71-3-503.
- (2) Exemption from Licensure.
 - (a) Any child care agency wishing to operate without a license must apply to the Department, in the form and manner directed by the Department, for recognition of legally exempt status pursuant to the provisions set forth in T.C.A. § 71-3-503. If a provider believes that the program meets one of the exemptions from licensure set out in T.C.A. 71-3-503, the agency may make a written request to the Department's Licensing Director for exemption from licensure that includes a full description of the program for which the exemption is being sought..

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- (b) A recognition of exemption from licensure by the Department does not preclude compliance by the child care agency with any other local, state, or federal requirements applicable to its operation.
- (3) Issuance of the license is based upon the following criteria:
 - (a) The safety, welfare and best interests of the children in the care of the agency;
 - (b) The capability, training and character of the persons providing or supervising the care to the children and the use of such judgment by a caregiver in the performance of any of the caregiver's duties as would be reasonably necessary to prevent injury, harm or the threat of harm to any child in care.
 - (c) The quality of the methods of care and instruction provided for the children;
 - (d) The suitability of the facilities provided for the care of the children; and
 - (e) The adequacy of the methods of administration and the management of the child care agency, the agency's personnel policies, and the financing of the agency.
- (4) The licensee must maintain compliance with the licensing criteria listed in paragraph (3) above and any other licensing criteria throughout the licensing year.
- (5) Foster Homes may not receive a license to operate a child care facility in the foster home. The Department may, in its discretion, waive this requirement if circumstances clearly warrant such an exemption. The written request for a waiver shall be submitted to the Department's Licensing Director.
- (6) Falsification of Information. Includes but is not limited to records, documents, and/or concealment of services or children from monitoring by the Department. Falsification of any information required for licensure shall be grounds for denial, suspension, or revocation of a license.
- (7) Scope of Licensed or Exempt Operation.
 - (a) All programs shall operate within the licensed capacity or exemption criteria, the hours of operation, the specific age ranges, services offered, and at the address designated on the license or at which the operation was exempted.
 - (b) All programs shall operate within any restrictions stated on the license.

Authority: T.C.A. §§ 4-5-202; 71-1-105(5) and (12); 71-3-501 et seq.; 71-3-502(a)(2) and (3); 71-3-503(a)(6),(8), and (9).

1240-4-3-.04 PROCEDURES FOR OBTAINING A LICENSE.

- (1) Licensing Procedures.
 - (a) The procedures for licensing, administrative actions, probation, civil penalties, suspension, denial and procedures for appeal are contained in Chapter 1240-4-5, 1240-4-7 and this Chapter.

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- (b) The Department may initiate administrative licensing action and judicial action against the licensee pursuant to any provisions of T.C.A. § 71-3-501 et seq. and Chapter 1240-4-5, 1240-5-7 and this Chapter.
 - (c) Any conflict between the definitions and procedures contained in Chapter 1240-4-5 and this Chapter shall be governed by the provisions of this Chapter.
- (2) When an individual or group is giving consideration to opening a child care service/business, the local county office of the Tennessee Department of Human Services should be contacted.
- (3) The applicant shall attend one pre-application training session which is provided by the Department. In the case of a program that is governed by a board of directors or trustees, this training shall be attended by the applicant. If the applicant is not responsible for the day to day management of the program this training shall be attended by both the applicant and the individual responsible for the day to day management.
- (4) In addition to the training required in paragraph (3) above, new directors/managers shall attend a pre-service orientation training which is provided by the Department and which is at least four (4) hours in length. In the case of a program that is governed by a board of directors or trustees, this training shall be attended by an individual who is responsible for the day-to-day management of the program.
- (5) A completed application form signed by the owner or the owner's authorized representative shall be submitted to the Department in the form and manner directed by the Department.
 - (a) The failure to fully complete all application forms and/or submit all required supporting documentation as directed by the Department shall void the application for license.
 - (b) Application fees must be submitted by certified check or money order prior to the issuance of a license. Exception: Government agencies may submit checks drawn on government accounts.
- (6) Issuance of a Temporary License to New Child Care Agencies shall require:
 - (a) Submission of all required application documentation and the license fee;
 - (b) Verification that the administrative structure of the agency, as required by subchapter 1240-4-3-.05, appropriately identifies and provides structures and procedures for the full-time management of the center;
 - (c) Verification that the qualifications for management positions fully comply with the requirements in Chapter 1240-4-3-.07 and paragraph (j), below;
 - (d) Verification of three (3) satisfactory references for the director/management;
 - (e) Verification that the physical facilities have received fire safety and environmental approval;
 - (f) Verification that the on-site director/manager has successfully completed a criminal background check and has a negative criminal history as required by T.C.A. § 71-3-507;
 - (g) Verification that the applicant and the personnel who will care for the children are capable in all substantial respects to care for the children;

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- (h) Verification that the applicant has the apparent ability and intent to comply with the licensing law and regulations;
 - (i) Verification by the Department, after appropriate on-site inspection, that the site is suitable for child care activities and does not endanger the welfare or safety of children;
 - (j) The applicant, owner, director or an employee of the agency has not previously been associated in an ownership or management capacity with any child care agency that has been cited by the Department for violations of this part or the Department's regulations, including the agency for which the application is pending, unless the Department determines that a reasonable basis exists to conclude that such individual is otherwise qualified to provide child care; and
 - (k) The criteria in 1240-4-3.-03(3) support the issuance of a restricted or unrestricted license.
- (7) Denial or Restriction of License.
 - (a) If the Department determines that any of the requirements set forth in this Chapter has not been, or cannot satisfactorily be met, then it may deny the application for a temporary license.
 - (b) If the Department determines that the conditions of the applicant's facility, its methods of care or other circumstances warrant, it may issue a restricted temporary license that permits operation of a child care agency, but limits the agency's authority in one (1) or more areas of operation.
 - (c) Appeals of the denial or restriction of a license are governed by Chapter 1240-4-5.
- (8) Terms of the Temporary Licensure Period.
 - (a) The temporary license shall remain in effect, unless suspended, for a period of one hundred and twenty (120) days, or until such time as the Department grants or denies the application for an annual license, whichever is later;
 - (b) During the one hundred and twenty (120) day temporary licensure period the licensee must attain and maintain compliance with all applicable licensing regulations; the failure to obtain and maintain such compliance during this period may result in the denial of the application for an annual license.
- (9) Evaluation Process for Annual License.
 - (a) The Department shall perform a minimum of two (2) visits to the child care center during the temporary licensing period, one (1) of which shall be unannounced.
 - (b) The Department shall perform at least one (1) observation of the caregivers' interaction with children during the temporary licensing period.
 - (c) The applicant must provide verification, including any required supporting documentation as directed by the Department, of compliance with all applicable licensing regulations.
 - (d) Within one hundred twenty (120) days of the issuance of the temporary license, the Department shall determine whether an annual or restricted annual license shall be issued to the applicant.

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- (e) The Department shall issue an annual license if the Department determines that the applicant:
 - 1. Has fully complied with all laws and regulations governing the specific classification of child care agency for which the application was made;
 - 2. Has demonstrated the ability attain and to maintain compliance with all licensing regulations during the annual license period; and
 - 3. Has a reasonable likelihood of maintaining the annual licensure.
 - (f) Upon issuance of an annual license, the licensee must maintain compliance with all applicable licensing regulations throughout the licensing period.
- (10) Re-licensure Evaluation Process.
- (a) Agencies currently licensed by the Department must submit an application for re-licensure prior to the expiration of the existing license. The failure to submit a complete application prior to the expiration of the current license shall result in the automatic termination of the annual license upon the expiration date.
 - (b) In addition to the evaluation requirements set forth in paragraphs (6) and (9), above, applicants for re-licensure shall be evaluated for the Report Card and Star-Quality Child Care Program as set forth in Chapter 1240-4-7.
- (11) Upon receipt of an application for a license, and throughout the temporary licensing period and during the licensing period, immediate access to all areas of the child care facility shall be granted to all Department representatives and other inspection authorities (i.e., fire safety, sanitation, health, etc.) during operating hours.
- (12) The Department may require the child care center to implement a plan to ensure the safety of the children in the care of the child care center at any time in the Department's determination its inspections or investigations or those of other local, state or federal agencies or officials may require it.

Authority: T.C.A. §§4-5-202; 71-1-105(5) and (12); 71-3-501 et seq.; 71-3-508(c).

1240-4-3-.05 OWNERSHIP, ORGANIZATION, AND ADMINISTRATION.

- (1) Statement of Purpose.
 - (a) An applicant for a license to operate a child care agency shall submit a written statement in the form and manner directed by the Department which provides the following information:
 - 1. A description of all services to be offered to children and parents;
 - 2. Ages of children to be served;
 - 3. Planned hours of operation;

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4. Meal service plan, including the number and type of meals and snacks to be served, as applicable;
 5. Admission requirements and enrollment procedures; and
 6. Plans for the provision for emergency medical care.
- (b) If, after being licensed, a licensee wishes to change the scope or type of service offered to children and families, an amended statement shall be filed with the Department for approval prior to implementation.
- (2) Organizational Structure.
- (a) The organization of every child care center shall be such that legal and administrative responsibility is clearly defined in writing in the form and manner directed by the Department and must accompany the application for a license.
 - (b) Every child care center shall have an on-site director.
 - (c) Following the issuance of an initial license a child care center may operate without an on-site director for a period of no more than sixty (60) days total within the licensing year. A qualified person, as determined by the Department, shall be in charge in the interim.
- (3) Finances.
- (a) In order to ensure the appropriate continuity of care for children the applicant must provide a reasonable plan with a proposed budget for the financial support of a center. The proposal must demonstrate adequate funding for both preliminary and ongoing costs associated with staffing, equipment and safe operation. Adequate financing of the center's operation shall be maintained throughout the licensing year.
 - (b) Proposed budgets and other relevant financial records shall be immediately available to the Department upon request.
- (4) Insurance
- (a) General liability, automobile liability and medical payment insurance coverage shall be maintained on the vehicles owned, operated or leased by the child care agency and on the operations of the child care agency's facilities as follows:
 1. General liability coverage on the operations of the child care agency facilities shall be maintained in a minimum amount of Five Hundred Thousand Dollars (\$500,000) per occurrence and Five Hundred Thousand Dollars (\$500,000) general aggregate coverage.
 2. Medical payment coverage shall be maintained in the minimum amount of Five Thousand Dollars (\$5,000) for injuries to children resulting from the operation of the child care agency.
 3. Automobile Coverage for agencies that transport children:
 - (i) Automobile liability coverage shall be maintained in a minimum amount of Five Hundred Thousand Dollars (\$500,000) combined single limit of liability.

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- (ii) Medical payment coverage shall be maintained in the minimum amount of Five Thousand Dollars (\$5,000) for injuries to children being transported in vehicles owned, operated or leased by the child care agency.
 - (b) The requirements of this subparagraph shall not apply to an agency that is under the direct management of a self-insured administrative department of the state, a county or a municipality, or any combination of those three (3), or that has, or whose parent entity has, a self-insurance program that provides, as determined by the Department, the coverages and the liability limits required by these rules.
 - (c) Documentation that the necessary insurance is in effect, or that the administrative Department or other entity is self-insured, shall be maintained in the records of the child care agency and shall be available for review by the Department.
- (5) Enrollment Restrictions.
- (a) Enrollment of children under six (6) weeks of age is prohibited.
 - (b) Children shall not be in care for more than twelve (12) hours in a twenty-four (24) hour period except in special circumstances (e.g., acute illness of or injury to parents, severe weather conditions, natural disaster, and unusual work hours). In such cases every effort shall be made to minimize the amount of time spent in the child care agency by exploring and documenting alternatives (i.e. part time care, care with a relative, etc).
 - (c) Individualized plans for the care of a child in excess of twelve (12) hours due to special circumstances shall be signed by parent and director, and approved by the Department. Plans shall be updated annually.
 - (d) The agency shall not admit a child into care until the parent/guardian has supplied the agency with a completed application, immunizations record (for children over two (2) months of age), and a health history.
 - (e) All children, regardless of whether enrolled in the agency shall be counted in the ratio and group size and shall have required records on file before care is provided.
 - (f) The agency shall maintain written documentation that the parent/guardian performed an on-site visit to the agency prior to the child being enrolled into care.
- (6) Requirements for Communication with Parents/Legal Guardians.
- (a) A copy of the agency's policies, procedures, and the Department's Summary of Licensing Requirements shall be supplied to the parent/guardian upon admission of the child.
 - 1. The agency's policies shall include criteria for the disenrollment of children.
 - 2. The agency shall require the parent/guardian to sign for receipt of the policies and Licensing Summary, and the signed receipt shall be maintained by the agency in the child's file.
 - (b) Parents/guardians shall be permitted to see the professional credential(s) of staff upon request.

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- (c) The agency shall implement a plan for regular and ongoing communication with parents. This plan shall include but not be limited to communication concerning curriculum, changes in personnel, or planned changes affecting children's routine care. Documentation shall be maintained for the most recent quarter.
- (d) During operating hours, parents/guardians shall be permitted immediate access to their children.
 - 1. The agency shall grant access to noncustodial parents/legal guardians if:
 - (i) The noncustodial parent/guardian provides the agency with a valid court order granting the noncustodial parent/guardian access to the child during agency operating hours; and
 - (ii) An Order of Protection or other legal document does not otherwise restrict or prohibit such access.
 - 2. The custodial parent/guardian may not prohibit or restrict, or require the agency to prohibit or restrict, the noncustodial parent/guardian's access to the child while in the care of the agency if the noncustodial parent/guardian meets the provisions of part (d)1, above.
 - 3. The agency may place reasonable restrictions on access by any parent/guardian as needed to limit disruption of the children's routines, e.g., limiting the number of days each week the parent may visit, the duration of the visit, etc. Any such limitations or restrictions must be clearly stated in the agency policy provided to the parent/guardian upon enrollment of the child.
- (e) Parents/guardians shall give written permission in advance of the child's removal from the premises, including prior notification and consent for each field trip. Exceptions shall be cases of emergencies or investigative procedures conducted pursuant to the child abuse laws.
- (f) Children shall be signed in and out of the center by the custodial parent/guardian or other person specifically authorized by the parent or the appropriate staff person. Center staff shall verify parental authorization and the identity of any person to whom a child is released.
- (g) An abuse prevention awareness program for parents shall be offered at least once a year. The program shall include a child abuse prevention component, as recognized by the Department of Human Services, with information on the detection, reporting, and prevention of child abuse in child care agencies and in the home.
- (h) Notifying Parents of Licensing Violations.
 - 1. Within the licensing year, after issuing two (2) formal notices of licensing violations, a notice of Probation, or after issuing any type of legal enforcement order, the Department may, in its discretion, require the agency to notify parents and funding sources of the circumstances. Such notification shall be a letter prepared by the Department to be provided to each parent or posted in the center with parents' signatures indicating they have seen the letter.

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2. The Department may, in its discretion, notify parents and funding sources of any decision rendered by the Child Care Agency Board of Review pursuant to Chapter 1240-4-5.

(7) General Record Requirements.

- (a) All records required by this chapter shall be maintained in an organized manner on-site at the agency and shall be immediately available to the Department upon request.
- (b) A child's records shall be kept for one (1) year following the child's leaving the agency. (Exception: The health record shall be returned upon request when the child leaves the agency.)
- (c) Staff records shall be maintained for at least one (1) year following the separation of the staff from the agency.

(8) Children's Records.

(a) General Requirements for Children's Records shall include:

1. A current information form which includes the child's name, date of birth, name of parent, child's and parents' home address, parents' business address, all phone numbers, work hours, any special needs or relevant history of the child or the child's family, and the name and address (home and business or school) of a responsible person to contact in an emergency if parents cannot be located promptly. This information shall be updated annually, or as changes occur;
2. Name, address, and telephone number of a physician to call in case of an emergency;
3. Written consent of parent/guardian regarding emergency medical care;
4. A child release plan stating to whom the child shall be released and a clear policy concerning the release of children to anyone whose behavior may place the children at immediate risk;
5. Written transportation agreement between parent/guardian and the center regarding daily transportation between the home and the center and the center and the school. If parents have a third-party transportation arrangement, verification and details of the arrangement shall be maintained in the child's file;
6. A copy of the child's health history provided by the child's parent, guardian/custodian or other caretaker, which need not be signed or certified by a health care provider, shall be on file in the center and shall be available to appropriate staff.
7. Daily attendance records that include the time in and time out for each child;
8. Prior written permission of parent/guardian for each field trip away from the premises;.
9. Immunization Record Requirements.

- (i) The agency shall maintain a written record in the child's file, as set forth in

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subparagraphs (b) and (c) below, verifying that the child has been immunized according to current Department of Health guidelines.

- (ii) Exceptions to immunization record requirements may be made only if:
 - (I) The child's physician or the health department provides a signed and dated statement, giving a medical reason why the child should not be given a specified immunization; or
 - (II) The child's parent/guardian provides a signed written statement that such immunizations conflict with his/her religious tenets and practices.

10. Reports of Accidents and Injuries.

- (i) Accidents and injuries shall be reported to parent or guardian as soon as possible but no later than child's release to parent or authorized representative.
- (ii) Accidents and injuries to children shall be documented immediately as follows:
 - (I) Date and time of occurrence;
 - (II) Description of circumstances, and
 - (III) Action(s) taken by the agency.
- (iii) Documentation of accidents and injuries to children shall be filed in the child's record no later than one (1) business day of occurrence.

(b) Preschool Children's Record Requirements.

1. Additional information shall be recorded and shared with parent daily for infants, toddlers and all non-verbal children which includes: time and amount of feeding, excessive spitting up, toileting, times of diaper changes, sleep patterns, and developmental progress.
2. Before a child under the age of thirty (30) months of age is accepted for care, the parent shall have proof of a physical examination within three (3) months prior to admission, signed or stamped by a physician or health care provider. This record must be kept on file at the agency.
3. A copy of each preschool child's immunization record, signed or stamped by a certified health care provider, shall be on file in the child care center and shall be available to the appropriate staff.

(c) School Age Children's Record Requirements.

1. The information form for school age children shall list the name, address, and phone number of the school the child attends.
2. Before a school-age child is accepted for care, the center shall have on file a statement from the parent (or the school) that the child's immunizations are current

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and that his/her health record is on file at the specified school which the child attends.

3. The records of any child who is five (5) years old in an agency which lacks approved kindergarten status for purposes of T.C.A. § 49-6-201 shall include a signed acknowledgment by the child's parents/guardians that recognizes that the child's attendance does not satisfy the mandatory kindergarten prerequisite for the child's enrollment in first grade. The statement of acknowledgment shall be signed by the parent/guardian and maintained in the child's file.

- (d) Record Requirements for Children with Special Needs. A daily activity record for children with special needs must be maintained.

(9) Staff Record Requirements shall include:

- (a) Name, birth date, social security number, address, and telephone number of all staff members, including volunteers, and a contact for each staff member in an emergency;
- (b) Educational background and educational experiences, including dates and places of diplomas received, and conferences, courses, and workshops attended in the preceding year;
- (c) The agency shall maintain documentation, signed by the examining licensed physician, licensed psychologist, licensed clinician, Nurse Practitioner or Physician's Assistant, verifying that the staff person is a physically, mentally and emotionally capable of safely and appropriately providing care for children in a group setting. The documentation shall be on file within three (3) business days of employment or starting to work;
- (d) An updated statement of each staff member's physical health shall be obtained every third (3rd) year or more often if deemed necessary by the Department;
- (e) At least three (3) written references, with documented interviews of each reference, on each new staff member;
- (f) Written, verified record of employment history;
- (g) Documentation of annual performance reviews;
- (h) Date of employment and date of separation from the agency;
- (i) Daily attendance (including time in/out) of staff;
- (j) Signed and completed criminal history disclosure form;
- (k) Verification of criminal background check results;
- (l) Verification of Vulnerable Person's Registry results; and
- (m) In addition, driver records shall contain:
 1. Copy of driver's license showing proper endorsement;
 2. Verification of a passed drug screen; and

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3. Verification of CardioPulmonary Resuscitation and First Aid Certification.

- (n) Records of volunteers with the agency must include the names, addresses, telephone numbers and dates of service for all volunteers shall be maintained on-site at the agency.

(10) Right to Privacy/Confidentiality.

The licensee and agency staff shall not disclose or knowingly permit the use by other persons of any information concerning a child or family except as required by law or regulation or as may be necessary to be disclosed to public authorities in the performance of their duties and which may be necessary for the health, safety, or welfare of any child enrolled at the center or his or her family.

(11) Posting of License, Report Card, and Other Required Documentation.

- (a) During the hours of operation, the current license to operate the child care center shall be posted near the main entrance in a conspicuous location.
- (b) During the hours of operation, the agency Report Card shall be posted near the main entrance in a conspicuous location.
- (c) The Department's toll-free child care complaint number shall be posted in a conspicuous location.
- (d) The local child abuse reporting number shall be posted near the main entrance in a conspicuous location and at each telephone.
- (e) A copy of all current applicable Department licensing rules shall be maintained in a central space and available to all staff and parents .
- (f) No smoking signs shall be posted in a conspicuous manner. Exception: This does not apply to child care operated in private residences.
- (g) The agency shall post any other materials as directed by the Department.

(12) Release of Children.

- (a) Children shall only be released to a responsible designated person in accordance with the child release plan required by these rules. The agency shall verify the identity of the authorized person by requiring presentation of a photo identification.
- (b) The person to whom the child is released must sign the child out of the agency.
- (c) Children shall not be released to anyone whose behavior may, as deemed by a reasonable person, place the child in imminent risk; provided, however, that if the agency reasonably believes that refusal to release the child could place staff or other children in imminent risk the agency may release the child, but must immediately call 911 or other local emergency services number.

Authority: T.C.A. §§ 4-5-202; 71-1-105(5) and (12); 71-3-501 et seq.

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1240-4-3-.06 SUPERVISION.

(1) Supervision Procedures.

- (a) The management of the agency shall maintain a system that allows personnel to know the whereabouts of each child in their care. This system shall include a mandatory visual inspection of all areas of the building and grounds immediately prior to closing the agency for the day in order to ensure that no children have been unintentionally left.
- (b) Children six (6) weeks of age through nine (9) years of age:
 - 1. The adult must be able to hear the child at all times, must be able to see the child with a quick glance, and must be able to physically respond immediately;
 - 2. Exception: while children are eating an adult must be in the direct sight and sound of the child;
- (c) Children ten (10) years of age and older: The adult shall know the whereabouts and activities of the children at all times and must be able to physically respond immediately;
- (d) Helper devices such as mirrors, electronic sound monitors, etc. may be used as appropriate to meet these requirements. However, the caregiver(s) must be in the same room with the children.
- (e) Caregivers shall monitor children's toileting and be aware of their activities while respecting the privacy needs of the child.
- (f) The agency shall maintain a plan approved by the Department that enables a caregiver in an emergency situation to call a second (2nd) adult while maintaining as much supervision of the children in care as is possible under the circumstances.
- (g) Section 504 of the Rehabilitation Act of 1973 and Americans with Disabilities Act (ADA) guidelines shall be consulted for care of children with disabilities relative to the number of caregivers which a reasonable accommodation of a child's disability may require.
- (h) When more than twelve (12) children are present on the premises but a second (2nd) adult is not required by the adult:child ratio rules contained in this Chapter, a second (2nd) adult must be physically available on the premises.
- (i) Children for whom care is provided by the center at any one time shall be included in the agency's enrollment, square footage allowance, and licensed capacity.
- (j) School-age children must be assigned to a specific caregiver. Upon arrival at the center each child shall be greeted and received by the caregiver to whom they are assigned. The assigned caregiver shall be responsible for the supervision and direction of the children assigned to their care.
- (k) The auxiliary staff shall not be included in the adult:child ratio, but can be used as emergency substitutes if their duties and qualifications permit.
- (l) If meals are served, any person responsible for preparing meals and washing the dishes shall not be included in the adult:child ratio while preparing these meals or washing dishes.

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- (m) When more than twelve (12) children in first grade and above are enrolled, a separate group space and a separate program shall be provided for them.
- (2) Assignment of Children to Groups.
 - (a) Each child must be on roll in a defined group and assigned to that group with a specific caregiver(s).
 - (b) In order to assure the continuity of care for children and their caregivers, the children should be kept with the same group throughout the day and shall not be moved or promoted to a new group until required based upon the developmental needs of the child;
 - 1. Exceptions.
 - (i) Groups, excluding infants and toddlers, may be combined for short periods for a special activity of no more than thirty (30) minutes duration per day as long as adult:child ratios are met.
 - (ii) Groups may be temporarily combined as set forth in paragraph (3), Adult: Child Ratio Chart 3, below.
 - (c) Each group must have a "home base" with enough space for the entire group.
- (3) Required Adult:Child Ratio.
 - (a) The adult:child ratios shall be maintained by the child care agency while the children are indoors and on the playground.
 - (b) Maximum group size requirements shall be maintained at all times when children are indoors with the exception of meals served in common dining rooms.
 - (c) When infants are cared for in a center with older children, they shall not be grouped with children three (3) years of age and over, and a separate area shall be provided for them.
 - (d) Extended Care: Children age thirteen (13) months and older may be grouped together while sleeping in overnight care.
 - (e) Adult/child ratios and group sizes in group child care homes and child care centers may exceed requirements set by the rule of the Department of Human Services by up to ten percent (10%), rounded to the nearest whole number, for no more frequently than three (3) days per week; provided, however, infant and toddler groups may never exceed the required ratios and group sizes. The Department may terminate the variance from the rule in individual cases under provisions for issuance of a restricted license pursuant to 71-3-502.
 - (f) Any number of children in excess of the adult:child ratios requires a second qualified adult caregiver; provider, however, that the maximum group size shall not be exceeded.
 - (g) Adult:Child Ratio Charts

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1. Chart 1—Single Age Grouping and Adult:Child Ratio Chart.

Maximum Group Size and Adult Child Ratios							
Single-Age Grouping	8	12	14	16	18	20	No Max
Infants: Six (6) wks.–Fifteen (15) mos.	1:4						
Toddlers (Twelve (12) mos.–Thirty (30) mos.)		1:6					
Two (2) years (Twenty-Four (24) mos.–Thirty-Five (35) mos.)			1:7				
Three (3) years					1:9		
Four (4) years						1:13	
Five (5) years						1:16	
School-Age (K and above)							1:20

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2. Chart 2—Multi-Age Grouping and Adult:Child Ratio Chart.

Maximum Group Size and Adult:Child Ratio										
Multi-Age Grouping	8	10	12	14	16	18	20	22	24	No Max
Infants/Toddlers: Six (6) wks.–Thirty (30) mos.	1:5									
Two (2)–Four (4) years					1:8					
Two and One-Half (2.5)–Three (3) years (Thirty (30)–Forty-Severn (47) mos.)						1:9				
Two and One-Half (2.5)–Five (5) years							1:11			
Two and One-Half (2.5)–Twelve (12) years	1:10									
Three (3)–Five (5) years (includes Three (3)–Four (4) years)								1:13		
Four (4)–Five (5) years									1:16	
Five (5)–Twelve (12) years										1:20

3. Combined grouping: first / last hour of each day only

- (i) Groups, excluding infants and toddlers, may be combined, for up to one (1) hour at the beginning and for up to one (1) hour at the end of the day as set forth in the following chart.
- (ii) Chart 3—Combined Groups and Adult:Child Ratios.

	Maximum Group Size and Adult Child Ratio							
	10	15	20					
2–12 years	1:10							
3–12 years		1:15						
4–12 years			1:20					

4. Naptime Supervision (Requirements for Naptime and Nighttime Care).

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- (i) At naptime and during nighttime care, after the children have settled down, adult:child ratios may be relaxed so long as the children are adequately protected and all of the following requirements are met:
 - (I) If there are sleeping or resting children, there shall be at least one (1) adult awake and supervising the children in each nap room/sleeping area;
 - (II) Infant/toddler ratios shall be maintained; and
 - (III) The adult:child ratio for children ages thirty-one (31) months and above can be fifty percent (50%) of the required ratio if there are enough adults on the premises so that the adult:child ratio required for children when they are awake shall be met immediately in an emergency.
 - (ii) Maximum group size limits do not apply as long as the appropriate adult:child ratio is met at the fifty percent (50%) level.
 - (iii) Sudden Infant Death Syndrome. Because of the possibility of Sudden Infant Death Syndrome:
 - (I) Infants shall be positioned on their backs when placed in a crib for sleeping.
 - (II) Soft bedding shall be avoided for infants.
 - (III) Infants should not be wrapped tightly in blankets for sleeping.
 - (IV) Infants shall be touched a caregiver every fifteen (15) minutes in order to check breathing and body temperature.
 - (V) Pillows shall be prohibited for infants.
 - (VI) If a child appears not to be breathing, the agency must immediately begin CPR and call for emergency medical assistance.
5. Playground supervision.
- (i) The same adult:child ratios are applicable for the playground as in the classrooms.
 - (ii) A playground supervision plan shall be maintained which includes:
 - (I) Arrival and departure procedures;
 - (II) Supervision assignments of staff to assure that all areas of the playground can be seen so that all children can remain within sight of the caregivers;
 - (III) Identification of which staff will merely supervise in their assigned zone while other caregivers, if any, interact with children as play facilitators;

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- (IV) Emergency plans specific to a variety of circumstances, such as, child injury, weather evacuation, toileting and other personal care needs of children or staff, etc.; and
- (V) A communication link among playground supervisors and a designated staff person, if available, inside the agency.

6. Transportation Supervision.

Supervision for transportation shall comply with rules in 1240-4-3-.13.

7. Supervision on Field Trips.

- (i) The adult:child ratios in the charts must be doubled during field trips. For example, the ratio for school-age children is 1:20 on the single aged grouping chart, thus a field trip involving up to 20 school age children would require two (2) caregivers.
- (ii) A minimum of two (2) caregivers are required for any field trip.
- (iii) The center must maintain a system utilizing an off-site attendance roll which tracks the whereabouts of each child while off the center premises e.g. (while off-site on a field trip).

8. When children are swimming, the following requirements shall be met:

Chart 4—Swimming Ratio Chart.

Age Group	Ratio
Infants(Six (6) wks-Twelve (12)months)	1:1
Toddlers/twos (Thirteen (13) –Thirty-Five (35) months)	1:2
Three (3) Year Olds	1:4
Four (4)Year Olds	1:6
Five (5) Year Olds	1:8
School-Age (K And Above)	1:10

- (i) Although group swimming for infants and toddlers/twos is not prohibited, it is not recommended due to the high risk.
- (ii) One (1) adult present shall have a current certificate in advanced aquatic lifesaving skills. This person must supervise from above the level of the swimmers, preferably from an elevated lifeguard chair or otherwise from the pool deck. If non-enrolled children are also monitored by the lifeguard, he/she may not be included in the required adult:child ratio.
- (iii) Remaining caregivers should supervise children both in and out of the water.

Authority: T.C.A. §§4-5-202; 71-1-105(5) and (12); 71-3-501 et seq.

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1240-4-3-.07 STAFF.

(1) Responsibility for Staff.

- (a) The board, owner, applicant/licensee, or other designated agent of the child care center shall be responsible for selecting qualified individuals of suitable character and ability to work with children.
- (b) The director, with the guidance of the board or owner of the center, shall be responsible for supervision, training and evaluation of the staff, the program and the day-to-day operation of the center.
- (c) Each location where children are kept shall have an on-site director.
- (d) To be designated as such, the on-site director of a child care center in operation up to twelve (12) hours a day shall be physically present in the center daily at least half of the total hours of operation. If a program operates more than one (1) shift the on-site director shall be physically present at least one shift.
- (e) To be designated as the director or person in charge (on a daily basis) of a multi-site child care program, he/she shall be employed full-time in that capacity.
- (f) An assistant director or other staff member shall be designated to be in charge in the absence of the director and all staff shall be notified of this designation.
- (g) Management shall evaluate all staff in the performance of their duties. Caregivers shall be evaluated for knowledge and understanding of growth and development patterns of children and understanding of appropriate activities for children as well as those with special needs.

(2) General Staff Qualifications.

- (a) Every staff person, including auxiliary staff, substitutes, volunteers, and practicum students, shall be physically, mentally, and emotionally capable of using the appropriate judgement for the care of children, and otherwise performing his/her duties satisfactorily.
- (b) A person who has a physical, mental, or emotional condition which is in any way potentially harmful to children shall not be present with the children.
- (c) At least one (1) adult available on the premises at all times during child care operating hours must be able to read and write English.
- (d) Prior to assuming duties, each new employee shall receive orientation in, and be able to explain:
 - 1. Program philosophy;
 - 2. Job description;
 - 3. Emergency procedures;
 - 4. Policies regarding discipline of children;

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5. Policies regarding the reporting of child abuse, and
 6. Policies for receiving and dismissing children.
- (e) Within the first two (2) weeks on the job, each employee (including auxiliary staff, such as bus driver, cook, etc.) shall receive instruction in:
1. Child abuse detection, reporting, and prevention;
 2. Parent-center communication;
 3. Disease control and health promotion;
 4. An overview of licensing requirements, and
 5. Information on risks of infection to female employees of childbearing age.
- (f) All training must be documented in the agency's records and be available for review by the Department's staff at anytime.
- (g) The agency must maintain written documentation that each employee has read the full set of all applicable licensure rules. In addition, a copy of such rules shall be maintained in an area readily accessible to all staff.
- (3) Multi-Site Personnel Qualifications.
- (a) Multi-Site Coordinator. The multi-site coordinator must meet the same requirements listed below for a single site child care center director.
- (b) Qualifications of On-Site Director under a Multi-Site Coordinator.
- (i) At least two (2) years of college training or a Department-recognized credential in addition to at least one (1) year of full-time (paid or unpaid) documented work experience with young children in a group setting; or
 - (ii) A high school diploma or equivalent educational credential recognized by the Department in addition to at least two (2) years of full-time (paid or unpaid) documented work experience with young children in a group setting.
- (4) Qualifications for Director of a Single Site Child Care Center.

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- (a) The director shall meet at least one (1) of the minimum qualifications listed in the chart below:

If Minimum Education Is:	The Minimum Group Care Experience Required Is:
Graduation from an accredited four-year (4-year) college	(1) year of full-time (paid or unpaid) experience in a group setting
Sixty (60) semester hours (two [2] years) of college training, with at least thirty (30) hours of which shall be in business or management, child or youth development, early childhood education or related field	Two (2) years of full-time (paid or unpaid) experience in a group setting
Tennessee Early Childhood Training Alliance (TECTA) certificate for completing thirty (30) clock hours of orientation training, or the equivalent as recognized by the Department	Two (2) years of full-time (paid or unpaid) experience in a group setting
High school diploma or equivalent educational credential recognized by the Department	Four (4) years of full-time (paid or unpaid) experience in a group setting
Has been continuously employed as an on-site child care director or a child care agency owner since July 1, 2000	Not Applicable

- (b) Training Requirements:

1. Prior to issuance of the first annual license. Owners (or a designee thereof who is not the on-site director) and directors shall complete a child care orientation course sponsored by the Department.
2. During the first year of employment a new director shall:
 - (i) Complete an orientation course sponsored by the Department within three (3) months of assuming their position; provided, however, that this course shall not be required if the director has:
 - (I) Received specific training meeting the requirements of this part within three (3) years prior to employment; or
 - (II) Earned a Bachelors degree, an Associates degree in child development or early childhood education, a CDA credential, or a CCP credential
 - (ii) Have evidence of receiving at least thirty-six (36) training hours, at least six (6) hours of which must be in administration, management or supervisory training; or
 - (iii) Earn credit for the year in one (1) academic course in administration, child development, early childhood education, health/safety or other related field.
3. After the first (1st) year of employment, the director shall:

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- (i) Have evidence of receiving at least eighteen (18) clock hours annually in workshops, training, or one-to-one consulting sessions
 - (I) At least six (6) hours of which shall be in administration, management or supervisory training;
 - (II) Four (4) hours of the required eighteen (18) hours may be earned by conducting training.
 - (ii) Shall earn credit during the year in one academic course in administration, child development, early childhood education, health/safety or other related field.
- (5) Assistant Director Qualifications.
 - (a) The on-site assistant director shall have at least two (2) years of college training or a Department-recognized credential and one (1) year of full-time (paid or unpaid) documented work experience in a group setting; or
 - (b) The on-site assistant director shall have earned a high school diploma or equivalent educational credential recognized by the Department and two (2) years of full-time (paid or unpaid) documented work experience in a group setting.
- (6) Caregivers.
 - (a) Each caregiver shall be at least eighteen (18) years of age. Exception: Sixteen (16) and seventeen (17) year-old students currently enrolled in a vocational child care program may be counted in the adult-child ratio; provided, however, that they shall always be under the direct supervision of an adult and shall not be left alone with a group of children.
 - (b) Each group shall have at least one (1) caregiver present who has a high school diploma or equivalent educational credential recognized by the Department.
 - (c) Training for Caregivers During the First (1st) Year of Employment.
 - 1. New caregivers shall complete, within the first (1st) thirty (30) days of employment with the agency, two (2) clock hours of pre-service orientation training offered or recognized by the Department. Pending completion of the orientation training, the caregiver's employment status as a caregiver with the agency is conditional.
 - 2. New caregivers shall additionally complete sixteen (16) hours of training recognized by the Department within the first (1st) year of employment, six (6) hours of which must be completed within the first six (6) months of employment.
 - 3. Failure of the caregiver to complete the required two (2) hours of pre-service orientation and/or failure to complete the required six (6) hours of training within the first (1st) six (6) months of employment shall require that the employee be removed from caregiver duties for children until completion of the training.
 - 4. Exception. Caregivers who have been employed in child care during the last three (3) years, hold a Bachelors or Associates degree in child development or a related field, or who hold a CDA credential or CCP credential as recognized by the Department

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shall instead comply with the training requirements for experienced caregivers required in section (d), below.

- (d) Training for Caregivers After the First (1st) Year of Employment.
 - 1. Experienced caregivers shall complete at least twelve (12) clock hours annually of training recognized by the Department.
 - 2. A maximum of two (2) hours training credit annually may be credited for Child and Adult Care Food Program (CACFP) training.
 - 3. At least six (6) hours of the required training must be non-agency based, e.g., obtained outside of the center.
 - 4. Up to four (4) hours training credit annually may be earned by conducting training.
 - 5. Credit for TECTA Orientation Training. Completion of a thirty (30) hour orientation class through the TECTA program shall satisfy the caregiver's minimum annual training requirements for two (2) years.
- (7) Substitutes.
 - (a) The names, addresses, telephone numbers and dates of service shall be recorded for all substitutes in the staff personnel records of the agency.
 - (b) Substitutes shall comply with the same orientation requirements of these rules for all agency staff.
 - (c) Substitutes who have acted as caregivers for two hundred (200) or more hours in the previous calendar year shall meet the training requirements contained in these requirements for caregivers.
 - (d) Substitutes providing services for thirty-six (36) hours or more in a calendar year shall:
 - 1. Meet the criminal background check requirements contained in these rules; and
 - 2. Meet the same requirements as regular staff for the physical examination required by these rules.
- (8) Practicum Students. Persons serving temporarily as caregivers in field service placements as part of an educational course of study or other curriculum requirement shall not be considered as substitutes for purposes of this rule.
- (9) Volunteers.
 - (a) Volunteers may be used to provide services and supplement the required caregivers or substitutes without payment, but are not counted to meet the adult:child ratios. If counted in the adult:child ratio, or provide services for more than twenty (20) hours per calendar week, volunteers shall be considered substitutes and must comply with the rules for caregivers or substitutes.
 - (b) Management shall be responsible for and supervise the activities of volunteers to assure safety of the children.

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- (c) Records for volunteers shall be maintained as required in 1240-4-3-.05.
- (10) Criminal Background Review and Abuse Registry Requirements; Exclusions from Contact with Children, Waivers from Exclusions; Appeals of Waiver Denials.
 - (a) Individuals Requiring a Fingerprint Criminal Background Review and Abuse (Vulnerable Persons) Registry Check:
 - 1. Any individual applying to work as a paid employee, director or manager of the child care agency in a position that will require or allow the individual to have contact with children at any time;
 - 2. Any individual applying to work as a new substitute and who is expected to offer at least thirty (36) hours of substitute services to the agency in any calendar year;
 - 3. Any individual applying for a license to operate a child care agency that is not the renewal of an existing license or any individual who otherwise seeks to be an operator, as defined by the rules of the department, of a child care agency as defined in § 71-3-501 and who has significant contact with children in the course of such role who will, in the course of their role as licensee, have significant contact with the children in care. For purposes of this paragraph, "operator" shall be an individual who is an owner or administrator of a child care agency or child care system;
 - 4. Residents of a New Agency. Any individual who is a resident of the child care agency and who is fifteen (15) years of age or older upon the agency receiving its initial license/approval; and
 - 5. New Residents of an Existing Agency. Any individual who is fifteen (15) years of age or older upon moving into a licensed/approved child care agency.
 - (b) Pending outcome of the criminal background check as described in this paragraph, the applicant for employment, a substitute or volunteer position, or for a license to operate shall be conditional and shall be dependent upon the results of the background check.
 - (c) Requirements for Submission of a Fingerprint Sample.
 - 1. Criminal History Disclosure Form. Individuals identified in subparagraph (a) shall complete and sign the Criminal History Disclosure Form provided by the Department.
 - (i) The failure to properly complete all sections of the Criminal History Disclosure Form shall result in the individual being prohibited from working, substituting, residing in or acting as a licensee for the child care agency.
 - (ii) The failure to disclose all criminal history information may result in the individual being:
 - (I) Excluded from working, directing, managing, operating, substituting, volunteering, residing in or acting as a licensee in any child care agency licensed by the Department; and
 - (II) Referred for criminal prosecution pursuant to the provisions of state law.

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2. Fingerprint Sample. The child care agency shall be responsible for obtaining, and submitting the fingerprint sample of any person required by subparagraph (a) above in the form and manner directed by the Department:
 - (i) Within ten (10) calendar days of the first day of beginning employment or substitute status;
 - (ii) Within ten (10) calendar days of the license application or seeking operator status;
 - (iii) Within ten (10) calendar days of the application for an initial license for a facility in which the person resides; or
 - (iv) Within ten (10) calendar days after the resident moves into the child care facility.
 3. Vulnerable Person's Registry. The child care agency shall be responsible for determining the status on the Department of Health's Vulnerable Persons Registry of any individual who is required by subparagraph (a) above to undergo a criminal history background check. Verification of such status check shall be maintained in the employee's record pursuant to the requirements set forth in 1240-4-3-.05.
- (d) Prohibited History.
1. No individual with a prohibited criminal history as defined below, regardless of whether such individual is required by these rules to undergo a criminal background check, may work, substitute or volunteer in a child care agency, nor be a resident, licensee, director or manager of a child care agency who has access to children or an operator who has significant contact with children or otherwise have unrestricted access to children in any manner whatsoever. .
 2. An individual shall be immediately and automatically excluded from child care or contact with children, as described above, if the individual's criminal history includes:
 - (i) A criminal conviction or a no-contest plea or pending criminal action (including warrants, indictments, presentiments), or who has or pretrial diversions awaiting final disposition);
 - (ii) A pending juvenile action or previous juvenile adjudication, which, if an adult, would constitute a criminal offense or lesser included criminal offense:

Involving any of the following crimes:

 - (I) Any crime (including a lesser included offense) involving a threat to the health, safety or welfare of a child;
 - (II) Any crime of violence (including a lesser included offense) against another person; and/or
 - (III) Any crime (including a lesser included offense) involving the manufacture, sale, distribution or possession of any drug.

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3. An individual shall also be immediately and automatically excluded from child care, as described above, if the individual:
 - (i) Reveals a potentially prohibited criminal history on the Criminal History Disclosure Form;
 - (ii) Is listed on the Department of Health's Vulnerable Persons Registry; and/or
 - (iii) Is known to the management or licensee of a child care agency as a perpetrator of child abuse or child sexual abuse or who is identified to the child care agency's management or licensee by the Department of Human Services or by the Department of Children's Services as a validated or indicated perpetrator of abuse of a child based upon an investigation conducted by the Department of Children's Services or by the child protective services agency of any other state or is identified to the child care agency's management or licensee as having a prohibited criminal history.
 4. Exclusion from driving duties. An individual with a prohibited history as set forth below shall be immediately and automatically excluded from providing driving duties to or on behalf of the child care agency:
 - (i) During the pendency of a criminal action (including warrants, indictments, presentiments), or who has or pretrial diversions awaiting final disposition) of any felony involving use of a motor vehicle while under the influence of any intoxicant or any felony which constitutes a violation of T.C.A. §§ 39-13-213; 55-10-101; 55-10-102 or 55-10-401; and
 - (ii) For a period of five (5) years from the date of the conviction or guilty plea of any felony involving use of a motor vehicle while under the influence of any intoxicant or any felony which constitutes a violation of T.C.A. §§ 39-13-213; 55-10-101; 55-10-102 or 55-10-401.
 5. Exclusions for Child Neglect. An individual who has been identified by the Department of Children's Services as having neglected a child based on an investigation conducted by that Department or any child protective services agency of any state, and who has not been criminally charged or convicted or pled guilty as stated above, shall be supervised by another adult while providing care for children.
 6. The child care agency shall immediately review the results of the criminal background check and Vulnerable Persons Registry review received from the Department and shall immediately exclude any individual with a prohibited history as directed by the Department.
 7. Failure to exclude. Failure to immediately exclude any individual as directed by the Department may result in the immediate suspension, denial or revocation of the child care agency's license.
- (e) Waivers from Exclusions Due to Criminal History.
1. Any person who is excluded or whose license is denied based upon the results of the criminal history background review may request, in writing to the Director of Licensing for the Department within ten (10) calendar days of receiving notice of such exclusion or denial, a waiver from the automatic exclusion requirements.

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2. Excluded individuals may, prior to receiving official notice of the exclusion or denial from the Department, make a written request for a waiver by letter or directly on the Department's Criminal History Disclosure Form.
3. Requests for a waiver shall state the basis for the request, including any extenuating or mitigating circumstances that would, in the person's opinion, justify an exemption from the exclusion. Any documentary evidence may also be submitted with the request.
4. Requests for waivers shall be heard and reviewed in accordance with the provisions set forth in T.C.A. §71-3-507.

Authority: T.C.A. §§ 4-5-202; 71-1-105(5) and (12); 71-3-501 et seq.; 71-3-507.

1240-4-3-.08 EQUIPMENT FOR CHILDREN.

(1) General.

- (a) The manufacturer's safety instructions shall be followed for the use and/or installation of all indoor and outdoor equipment and appliances. Such instructions shall be retained and communicated to all appropriate staff.
- (b) All indoor and outdoor equipment shall be well made and safe. There shall be no dangerous angles, no sharp edges, splinters, protruding nails, nuts and bolts, heavy or hard seats, head entrapment spaces, no open S-hooks or pinch points, etc. within children's reach.
- (c) Electrical cords on equipment for children shall be inaccessible to the children
- (e) Damaged or unsteady equipment shall be repaired or removed from the room or playground immediately.
- (f) Equipment shall be kept clean by washing frequently with soap and water.
- (g) There shall be developmentally-appropriate equipment and furnishings for each age group in attendance.
- (h) Individual lockers or cubbies, separate hooks and shelves or other containers, placed at children's reaching level, shall be provided for each child's belongings.
- (i) In infant/toddler rooms, equipment and space shall be provided for climbing, crawling, and pulling without the restraint of playpens or cribs.

(2) Indoor Play Equipment.

- (a) Pieces of equipment, such as television sets, bookcases, shelves and appliances, shall be secured or supported so that they will not fall or tip over.
- (b) Sufficient indoor equipment, materials, and toys shall be available to:
 1. Meet the active and quiet play needs of all children enrolled;
 2. Provide a variety of developmentally appropriate activities so that each child has at least three (3) choices during play time; and

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3. Adequately provide for all the activities required in the Program subchapter of these rules.
- (c) Toys, educational, and play materials shall be organized and displayed within children's reach so that they can select and return items independently.
- (d) Teaching aids that are small or that have small parts that can be inhaled or swallowed shall be inaccessible to infants and toddlers.
- (3) Outdoor Play Equipment.
 - (a) There shall be developmentally appropriate outdoor play equipment for children who are in care more than three (3) daylight hours.
 - (b) All outdoor play equipment and materials shall be sufficient in amount and variety so that children have an opportunity to participate in a minimum of at least three (3) different types of play using either stationary equipment and/or portable play materials.
 - (c) All outdoor play equipment shall be placed to avoid injury:
 1. Fall zones shall extend six (6) feet away from the perimeter of equipment and away from retainer structures, fences, and other equipment and out of children's traffic paths;
 2. Agencies with a playground continually licensed since prior to January 1, 2002 shall be permitted to maintain fall zones of at least four (4) feet; provided, however that any expansion or addition shall comply with the six (6) foot fall zone required by part 1, above.
 - (d) Anchorage.
 1. Supports for climbers, swings, and other heavy equipment that could cause injury if toppled shall be securely anchored to the ground, even if the equipment is designed to be portable.
 2. Portable equipment shall otherwise be anchored to the ground if the height & weight of equipment exceeds the height & weight of smallest child who will use the equipment.
 - (e) An acceptable resilient surfacing material, as recognized by the Department, shall cover fall zones in accordance with the following chart:

Resilient Surfacing Material	Minimum Acceptable Depth
Wood chips or Mulch	Six (6) inches
Double Shredded Bark	Six (6) inches
Pea Gravel	Six (6) inches
Medium Gravel	Eight (8) inches
Fine Sand	Eight (8) inches
Course Sand	Eight (8) inches

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(4) Naptime and Sleeping Equipment.

- (a) Napping or sleeping equipment shall be available for each preschool child who is in care for six (6) hours or more.
- (b) A quiet rest area and cots or mats shall be available for all children who want to rest or nap. However, no child shall be forced to nap.
- (c) No child shall be forced to stay on a cot or on a mat for an extended period of time.
- (d) All nap/sleep equipment shall be clean and in good repair, and shall comply with the following requirements:
 - 1. Individual cots or two-inch (2") mats shall be provided for children ages twelve (12) months through five (5) years, and shall be labeled with each child's name.
 - 2. Individual beds or cots shall be provided for children sleeping for extended periods of more than two and one half (2 1/2) hours, such as during nighttime care.
 - 3. A clean sheet or towel shall be used to cover whatever the child sleeps on.
 - 4. A clean coverlet shall be available to each child.
 - 5. Each child under twelve (12) months shall have an individual, free-standing, crib (at least twenty-two inches (22") x thirty-six inches (36") with an open top.
 - 6. Mattresses and foam pads shall be covered with a safe, waterproof material.
 - 7. Soiled sheets and coverlets shall be replaced immediately.

Authority: T.C.A. §§ 4-5-201 et seq.; 71-1-105(12); 71-3-501 et seq.

1240-4-3-.09 PROGRAM.

(1) Schedule and Routines.

- (a) Routines such as snacks, meals, and rest shall occur at approximately the same time each day.
- (b) There shall be a balance between child's choice and adult-directed activities.
- (c) There shall be alternating periods of vigorous activity and quiet play or rest throughout the day.
- (d) Special consideration shall be given to providing early morning and late afternoon activities that will help children cope with possible unhappiness over separation from parents/guardians and end-of-day fatigue.
- (e) Each caregiver shall be responsible for providing consistent care for a specific infant(s)/toddler(s). "Consistent care" includes, but is not limited to: planning, record-keeping, communication and general interaction, and routine care.

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- (f) The caregiver(s) shall give individual attention to each child, in addition to the time devoted to diapering and feeding.
 - (g) Children shall not be left in restraining devices such as swings, car seats, or high chairs (in excess of thirty (30) minutes). Care shall be given to provide stimulation to children in those settings.
 - (h) Opportunities shall be provided for children to interact with one another.
 - (i) Opportunities shall be provided for children to be by themselves to play alone or do homework, if they choose, in a small quiet area away from other activities.
 - (j) Children ten (10) years and older shall be encouraged to participate in the planning of their own schedules and activities.
 - (k) Extended Care. Children shall be given the same opportunities for developmentally appropriate activities during extended care hours as during conventional care hours.
- (2) Television, Videos, and Computers.
- (a) Programs/movies with violent or adult content (including “soap operas”) shall not be permitted in children’s presence.
 - (b) Programs/movies/computer games shall be developmentally appropriate for the viewers.
 - (c) Parents/guardians shall be informed of movie showings and video/computer games and their ratings.
 - (d) Videos, movies, and video/computer games must be previewed by staff for content.
 - (e) If television, video tapes, video/computer games, and/or movies are used, they shall be limited to:
 - 1. Two (2) hours per day, or the length of a movie if more than two (2) hours in the case of school-agers.
 - 2. Extended Care: Television viewing by children during night care between 6 pm and 6 am, shall be limited to one (1) hour.
 - (f) All programs shall be designed for children’s education and/or enjoyment.
 - (g) Up to one (1) additional hour per day, but not more than three (3) days per week, can be added to viewing time for computer use.
 - (h) School-age children may use computers for completion of homework with no time limitations.
 - (i) Computers, if used, shall be located in view of a caregiver for monitoring purposes.
 - (j) Computers which allow internet access by the children shall be equipped with monitoring or filtering software, or an analogous software protection, which limits children’s access to inappropriate web sites, e-mail, and instant messages.

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- (k) Other activity choices shall be available to children during television/movie viewing or computer use.
- (3) Outdoor Play and Playground Routines.
- (a) An opportunity for outdoor play shall be extended to children of all ages who are in care more than three (3) daylight hours; provided, however, for agencies where outdoor play is prohibitive or dangerous, as determined in the discretion of the Department, unoccupied indoor space providing fifty (50) square feet per child is acceptable.
 - (b) Children shall be allowed to experience a variety of weather conditions:
 - 1. Children shall be provided an opportunity for outdoor play when the temperature range, after adjustment for wind chill and heat index, is between thirty-two (32) degrees and ninety-five (95) degrees Fahrenheit and not raining;
 - 2. Children shall be properly dressed and the length of time outside adjusted according to the conditions and the age of the children.
 - (c) Caregivers shall be alert for signs of dehydration, heat stroke, frostbite, etc. dependent upon the season.
 - (d) Each agency shall develop a set of age appropriate playground rules that uses positive language. Rules should be posted in each play area.
- (4) Reclining Rest Period:
- (a) A reclining rest period of at least one (1) hour shall be provided for all preschool children in care for six (6) hours or more. Extended care: Children should be allowed reasonable rest time as indicated in the extended night care schedule.
 - (b) Each child shall be allowed to form his own patterns of sleep.
 - (c) A child shall not be left in a crib or on a cot for an unreasonable length of time.
- (5) Behavior Management and Guidance.
- (a) Attention spans and skills of children shall be considered so that caregivers do not require children to engage in developmentally inappropriate behavior.
 - (b) Discipline shall be reasonable, appropriate, and in terms the children can understand.
 - (c) Discipline that is potentially shaming, humiliating, frightening, verbally abusive, or injurious to children shall not be used.
 - (d) Discipline shall not be related to food, rest, or toileting.
 - (e) Spanking or any other type of corporal punishment is prohibited. ("Corporal punishment" is the infliction of bodily pain as a penalty for behavior of which the punisher disapproves.)
 - (f) Caregivers shall not focus solely upon unacceptable behavior.
 - (g) Praise and encouragement of good behavior shall be used.

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- (h) Efforts shall be made to help children develop a feeling of self-worth beginning at infancy and continuing throughout the school-age years.
- (i) When a child is engaging in unacceptable behavior the caregiver should, prior to disciplining the child, first distract the child's attention and substitute a desirable activity.
- (j) Time out shall be reasonable and developmentally appropriate.
 - 1. Time out shall take place in an appropriate location within sight of the caregiver.
 - 2. The length of each time out session shall be based on the age of the child and shall not exceed one (1) minute per each year of age of the child; provided, however, that in no event shall any child below the age of thirty-six (36) months be placed in time-out for more than three (3) minutes, and no child between thirty-six (36) months and sixty (60) months of age shall be placed in time-out for longer than five (5) minutes.
- (k) Physical Restraint. In order to avoid a high risk of physical injury or death, and in order to maintain a child's emotional health, the use of physical restraint for behavior management is prohibited unless all of the following requirements are met:
 - 1. Restraints shall only be used after all other means of controlling the behavior have been exhausted and a child is at the point of injuring himself/herself or other children;
 - 2. Prior to using physical restraint the agency shall have developed a clear written policy on the acceptable use of physical restraints that is approved by the Department and which includes, at a minimum, the following:
 - (i) Criteria, including medical authorization, for the identification of specific individual children for whom the use of physical restraints is not prohibited;
 - (ii) Criteria for the identification and authorization of specific individual staff to administer the physical restraint;
 - (iii) Provisions for the initial and ongoing training of staff authorized to administer physical restraint;
 - (iv) Provisions for alternative available methods of behavior management and procedures requiring their use prior to administering physical restraint;
 - (v) Procedures for the immediate notification of the parent/guardian after physical restraint is administered; and
 - (vi) Policies and procedures for insuring compliance with all other requirements contained within this subparagraph (k).
 - 3. The agency shall maintain in the child's health record required by 1240-4-3-.05 a written statement, updated annually and signed by a physician or licensed clinician, which states that the child does not have any medical or physical condition that would contraindicate the use of physical restraint. The agency is prohibited from administering physical restraint on any child whose health record does not contain this current statement;

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4. The agency shall maintain written documentation, signed by the parent/guardian, that the possible use of physical restraint has been discussed and explained in detail with the parent/guardian at the time their child is enrolled in the agency;
 5. Physical restraint shall only be administered by staff members who have completed training approved by the Department on the proper administration of physical restraint;
 - (i) This training shall be updated annually.
 - (ii) The agency shall maintain documentation of the training in the staff record required by 1240-4-3-.05.
 6. The agency is prohibited from administering physical restraint unless a second (2nd) trained staff member is available on the premises to assist.
 - (i) The second (2nd) trained staff member shall be called immediately upon the determination being made that physical restraint will be necessary;
 - (ii) Untrained staff are prohibited from assisting in any manner whatsoever in the administration of the physical restraint.
 7. Administration of the physical restraint must cease immediately upon the child no longer posing an imminent threat to herself/himself or other children, regardless of whether the child is continuing to exhibit inappropriate or unacceptable behavior. Emergency 911 or local emergency services must be contacted if a child continues to pose a threat to himself/herself after five (5) minutes of restraint.
 8. After an incident using physical restraint the agency shall create a written incident report within one (1) business day that is available to the parent/guardian and to the Department and which documents:
 - (i) The date and time the potentially dangerous behavior began;
 - (ii) A description of the means in which the behavior escalated;
 - (iii) All alternative methods which were used to manage the behavior;
 - (iv) The exact methods, including a physical description, used to administer the restraint;
 - (v) The child's physical appearance and behavior following administration of the restraint; and
 - (vi) The identification of all staff who interacted with the child in any manner whatsoever during this time period and the nature of their interaction;
- (4) Physical Care-Toilet Training.
- (a) Toilet training shall never be started until a child has been in the child care setting long enough to feel comfortable.
 - (b) Toilet training shall not be started until a child is able to understand, to do what is asked of them, and to communicate their need to use the bathroom.
 - (c) Children shall not be made to sit on the potty or toilet for more than five (5) minutes.
 - (d) Children shall be diapered or cleaned immediately in a safe, sanitary manner.

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(5) Educational Activities.

- (a) Activities shall be based on developmentally appropriate educational practices.
- (b) A daily program shall provide opportunities for learning, self-expression, and participation in a variety of creative activities such as art, music, literature, dramatic play, science, and health.
- (c) Staff shall plan ahead for developmentally appropriate activities; written lesson plans shall be provided for children of each age group.
- (d) Indoor physical activities, requiring children to use both large and small muscles, shall be provided for children of each age group.
- (e) For infants/toddlers, a portion of the day shall include floor time for activities that develop physical, social, language and cognitive skills.
- (f) Because of the importance of language development and communication skills infants and toddlers shall have language experiences on a daily basis.
- (g) For ages three (3) through school-age, the curriculum shall include instruction in personal safety as needed but at least once a year. The personal safety curriculum shall include a prevention of child abuse component, recognized by the Department.
- (h) For school-age children the curriculum shall include instruction on reporting physical, verbal or sexual abuse.

(6) Extended Care.

- (a) Agencies providing nighttime care shall meet the following additional requirements:
 - 1. Calming activities preceding bedtime shall be provided, e.g., listening to a story or soft music. In addition, individual/adult attention shall be provided as needed.
 - 2. Routine personal hygiene shall be encouraged and supervised. A plan shall be made with parents for brushing teeth, baths, bed dress, etc.

Authority: *T.C.A. §§ 4-5-201 et seq.; 71-1-105(12); 71-3-501 et seq.*

1240-4-3-.10 HEALTH AND SAFETY.

- (1) Children's health records shall be maintained as directed under subchapter 1240-4-3-.05
- (2) Children shall be immunized in accordance with current Department of Health guidelines unless exempted pursuant to 1240-4-3-.05. The agency shall maintain written policies for the disenrollment of children who fail to comply with Department of Health immunization guidelines in a timely manner.
- (3) Children shall be checked upon arrival and observed for signs of communicable disease during the day.
- (4) A child's temperature must be taken using a non-invasive method unless otherwise prescribed by a physician.

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- (5) Symptomatic children shall be removed from the group until parents are contacted and health issues are resolved.
- (6) Universal precautions, as defined by the Department of Health, shall be followed when handling or cleaning bodily fluids.
- (7) First Aid.
 - (a) A standard first aid kit (for example, one approved by the American Red Cross) shall be available to all staff, and all staff shall be familiar with its contents and use.
 - (b) At least one staff member who has current certification or equivalent in first aid from a certifying organization recognized by the Department shall be on duty at all times. The course shall be a minimum of three (3) hours and shall be taught by a certified first aid instructor. Extended Care: All staff shall have certification or equivalent in first aid from a certifying organization recognized by the Department.
 - (c) Current and comprehensive first aid information shall be available to all staff who interact with children and the agency shall provide periodic training and updates on basic first aid and the use of the first aid kit.
- (8) Emergency Treatment.
 - (a) At least one staff member shall hold current certification in Infant/Pediatric Cardiopulmonary Resuscitation (CPR) from the American Red Cross, the American Heart Association, or other certifying organization, as recognized by the Department. Extended Care: All staff shall be certified in Infant/Pediatric Cardiopulmonary Resuscitation (CPR) from a certifying organization recognized by the Department.
 - (b) The initial course shall be a minimum of four (4) hours and shall be taught by an individual currently certified, as recognized by the Department, to provide CPR instruction.
 - (c) When school-age children are present, and/or in a school-age only program, at least one staff member shall hold current certification, pursuant to the requirements listed in subparts (a) and (b) above, in Adult CPR. Extended Care: All staff should be certified pursuant to the to the requirements listed in subparts (a) and (b) above, in adult CPR.
- (9) Preparation for Emergencies.
 - (a) The agency, in consultation with appropriate local authorities, shall develop a written plan to protect children in the event of disaster such as, but not limited to, fire, tornado, earthquake, chemical spills, floods, etc. and shall inform parents of the plan.
 - (b) The agency shall implement these emergency procedures through timely practice drills to meet local regulations and shall maintain documentation of drills for one year. Extended Care: At least one (1) of these drills should be conducted during extended care hours.
 - (c) The following emergency telephone numbers shall be posted next to all telephones and be readily available to any staff member :
 - 1. Fire Department,
 - 2. Police Department/Sheriff,

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3. Nearest Hospital Emergency Room,
4. Child Abuse Hotline,
5. Local Emergency Management Agency,
6. Ambulance or Rescue Squad, and
7. Poison Control Center.

- (d) If a generic number (such as, but not limited to, 911) is operable in the community, it shall be posted in addition to the above numbers. All contact numbers for parents/guardians shall be readily available to all staff.

(10) Contagious Conditions:

- (a) Impetigo and diagnosed strep shall be treated appropriately for twenty-four (24) hours prior to readmission to the center.
- (b) Children diagnosed with scabies or lice shall have proof of treatment and be free of nits prior to readmission.
- (c) The agency may not provide care and/or isolation for a child with a contagious condition unless written instructions are obtained from a licensed physician or certified health care provider.
- (d) Parents of every child enrolled shall be notified immediately if one of the following communicable diseases has been introduced into the agency:
 1. Hepatitis A,
 2. Food borne outbreaks (food poisoning),
 3. Salmonella,
 4. Shigella,
 5. Measles, mumps, and/or rubella,
 6. Pertussis,
 7. Polio,
 8. Haemophilus influenza type B,
 9. Meningococcal meningitis, and
 10. Any other illness identified by the state or local Department of Health.
- (e) The agency shall report the occurrence of any of the above diseases to the local health department as soon as possible, but no later than the end of the day in which it occurred.

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(11) Notification of Parents of Accidents, Injuries, Illnesses.

- (a) Serious injuries, including but not limited to, massive bleeding, broken bones, head injuries, possible internal injury, etc. shall be reported to the parent/guardian immediately to arrange for emergency treatment.
- (b) Signs of serious illness, including but not limited to, high temperature, disorientation, coughing, vomiting or diarrhea with blood present, severe difficulty breathing, seizure, etc. shall be reported to the parent/guardian immediately to arrange for emergency treatment.
- (c) Accidents, injuries, and every sign of illnesses shall be reported, or a reasonable attempt made to report, to the parents as soon as possible, but no later than child's release to parent or authorized representative.
- (d) In no event shall the agency delay seeking emergency treatment due to a delay in making contact with the parent/guardian.

(12) Medications.

- (a) All medications, prescribed and non-prescribed, shall be received from the parent or guardian by a designated staff person or management level staff person.
- (b) An alternate staff person shall be available to administer medication in the event the designated staff person is absent.
- (c) The staff person designated in subparagraph (a) above shall document verification of the following:
 - 1. The parent's or guardian's written authorization to administer each medication;
 - 2. That the medicines or drugs are in the original prescription container, are not out of date, and are labeled with the child's name;
 - 3. The specific dosage and times the medication is to be administered to the child; and
 - 4. That the parent or guardian has provided the agency with instructions on the methods of administration;
- (d) The following documentation of administration shall be maintained in the child's file and a copy provided to the parent/guardian:
 - 1. Times medications administered;
 - 2. Noticeable side effects; and
 - 3. Name of staff person administering medication to child;
- (e) The parent/guardian shall sign documentation verifying that:
 - 1. The administration information required by subparagraph (c) above was received, and

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2. Unused medication was returned to the parent/guardian.
 - (f) Medication shall not be handled by children. Exception: A physician's authorization for the current school year shall be on file for school-age children who must have self-administered medication.
 - (g) Medication shall never be administered in bottles or infant feeders unless authorized by a physician.
 - (h) Accessibility.
 1. All medications, prescriptions and non-prescription, whether requiring refrigeration or not, shall be stored in a locked compartment or container.
 2. If medications requiring refrigeration are kept in a refrigerator used for food storage, the medicine shall be put in a leak-proof locked container.
 3. Keys for these compartments/containers shall be inaccessible to children.
 4. Exception for Emergency Administration: Medication requiring emergency administration, as directed by the physician, nurse practitioner or physician's assistant, e.g., "Epi-Pen", asthma inhaler, etc., may be kept in an unlocked container that is inaccessible to children.
 - (i) Unused medications shall be returned to the parent/guardian.
- (13) Prohibited Practices and Products.
- (a) Smoking
 1. Smoking is not permitted in the presence of children.
 2. Under state law, smoking in child care centers that are not private homes is restricted within a child care facility to areas where children are not permitted access, and parents must be given notice that the facility has a smoking area.
 - (i) No smoking signs must be posted conspicuously within the facility as provided by state law.
 - (ii) Federal law prohibits smoking in any part of a child care facility that is not a private residence if the facility is constructed, operated, or maintained with Federal funds.
 - (b) Alcoholic Beverages.
 1. The use of alcoholic beverages is not permitted in child care centers during the hours of operation of the center.
 2. Alcoholic beverages shall not be in the designated child care space when children are present.
 - (c) Illegal or inappropriate activities on the premises, property, or vehicle, or any activity that otherwise places children at risk are prohibited.

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- (d) Firearms shall not be on the premises of a child care agency or in the presence of a child. Exception: In a private residence, firearms and other deadly weapons or tools on the premises shall be secured in such a way that they are inaccessible to children.
- (e) Kitchen knives and other potentially dangerous utensils or tools shall be secured so that they are inaccessible to children.
- (f) Staff's personal belongings (such as, but not limited to, contents of purses, backpacks, coat pockets, diaper bags, etc.) shall be inaccessible to children at all times.

(14) Diapering.

- (a) Children shall be diapered/changed and cleaned immediately when wet or soiled.
- (b) For the protection of children and adults, the Centers for Disease Control guidelines for handwashing and diapering procedures shall be followed.
- (c) The diapering area and/or toilet training area shall be located near a handwashing lavatory and shall be located in a separate area from the food preparation area.
- (d) All diapering surfaces shall be off the floor, nonporous, and shall be sanitized using the following cleaning solutions for general cleaning and sanitizing purposes:
 - 1. For general cleaning and sanitation purposes, a fresh solution of one quarter (1/4) cup chlorine bleach to one gallon of water (or one (1) tablespoon chlorine bleach to (1) quart of water) must be made daily.
 - 2. Substitutions for the bleach solution required in part 1, above, that are approved for the child care setting by the Department of Health are permissible.
 - 3. The solution required in part 1 above is not appropriate for items associated with food preparation or for items that children frequently place in their mouths, and the Health Department does not permit the use of higher concentration than these in food preparation areas. Specific jurisdictions may have even more stringent requirements; therefore, the local health department should be consulted.
- (e) Special Needs Children.
 - 1. If older children are enrolled who lack independent toileting abilities, rules regarding diapering of preschool children shall apply.
 - 2. Children shall be changed in a location designated for that purpose and which provides privacy from other children and adults.
 - 3. School-age children may be diapered on the floor on a nonporous, washable diapering surface that adequately protects the floor from contamination.
 - 4. The floor beneath the diapering surface shall be immediately cleaned after each diapering.
 - 5. The diapering area shall be located near a handwashing lavatory. This area shall be in a separate location from the food preparation area.

(15) Naptime Care.

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- (a) In order to avoid the spread of airborne diseases children should be positioned on mats in a face to feet alternating pattern.
 - (b) Spacing of cots, cribs, and mats shall allow sufficient space to walk between them.
- (16) Tuberculosis Screening.
 - (a) Tuberculosis (TB) screening prior to on-going contact with children is required for any individual who:
 - 1. Was born in a country other than the United States, Canada, Western Europe, Australia, New Zealand, and Japan;
 - 2. Has a weakened immune system (Human Immunodeficiency Virus [HIV], cancer, taking chemotherapy drugs, etc.); or
 - 3. Has been recently exposed to tuberculosis.
 - (b) Any individual who has had a cough for three (3) weeks or longer should be evaluated by a physician for tuberculosis.
 - (c) Future screening is not required for individuals who have been treated for TB or latent TB infection unless persistent pulmonary symptoms develop or there is contact with tuberculosis.
 - (d) All Foreign-born children (born in countries other than Canada, Western Europe, Australia, New Zealand, and Japan) shall present evidence of a tuberculin skin test performed in the United States at any time after twelve (12) months of age. Any child with a positive tuberculin skin test shall be referred to a physician for evaluation. After the initial evaluation, future periodic screening is not required unless the child develops persistent pulmonary symptoms or there is contact with tuberculosis
- (17) Staff Health.
 - (a) Staff health records shall be maintained as directed under subchapter 1240-4-3-.05.
 - (b) A statement of mental or emotional health shall be obtained from a psychiatrist or clinical psychologist when deemed necessary by the Department.
- (18) Duty to Report Child Abuse and Neglect.
 - (a) Duty to Report.
 - 1. Every operator, owner, licensee, director, or staff member of, or substitute staff member or volunteer in, a child care agency licensed by the Department of Human Services is individually responsible, and is required by Tennessee Code Annotated, Sections 37-1-403 and 37-1-605, to immediately report any reasonable suspicion of child abuse or neglect to either the Department of Children's Services and/or local law enforcement or the judge of the juvenile court in the county of the child's residence.
 - 2. Determining Suspicion of Abuse/Neglect.

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- (i) Due to both the immediate risk children's safety, as well as to the extreme risk of destroying critical evidence, the agency and/or individual staff shall not delay reporting possible abuse or neglect in an attempt to conduct an investigation in order to verify the abuse/ neglect allegations.
 - (ii) In determining a reasonable suspicion, the agency shall limit questioning of the child and may make only the most basic inquiries necessary to determine if any reasonable possibility of abuse or neglect exists.
 - (iii) The agency does not have to, and shall not attempt to, validate (or "prove") the allegation prior to making a report as required by this paragraph. A final determination of the validity of the report of abuse or neglect shall be made exclusively by the Department of Children's Services and/or by law enforcement based upon the report by the child care agency's staff.
- 3. Each center shall develop procedures, approved by the Department, for staff to follow to report suspected abuse and neglect.
- 4. Any report of abuse/neglect from a child or any evidence of abuse/neglect observed on a child shall be immediately reported by staff to the local Department of Children's Services, local law enforcement or the judge of the juvenile court in the county of the child's residence.
- (b) The telephone numbers of the Department of Children's Services, the local law enforcement or the juvenile judge of the county of the child's residence for staff to call to report suspected abuse and neglect shall be posted in a conspicuous location by each telephone.
- (c) Prohibited Procedures for Reporting Suspected Child Abuse/Neglect/Penalties.
 - 1. The agency shall not develop or implement policy that requires any staff, including volunteers, and shall not otherwise directly or indirectly require staff, to report to or seek the approval of agency management prior to any individual staff member reporting the suspected abuse as required by subparagraph (a) above.
 - 2. A report of suspected child abuse or neglect of a child enrolled in the child care agency by the operator, owner, licensee, director or staff member of, or substitute staff member or volunteer in, a child care agency shall not be made to any other entities or persons, including, but not limited to, hospitals, physicians, or educational institutions as an alternative to or substitute for the reporting requirements of subparagraph (a).
 - 3. The operator, owner, licensee, director, or staff member of, or substitute staff member or volunteer in, the child care agency shall not suggest to, or advise or direct a parent or caretaker of a child enrolled in the child care agency to make a report of suspected child abuse or neglect regarding that parent's or caretaker's own child who is enrolled in the child care agency as a means of fulfilling the duty of the operator, owner, licensee, director, or staff member of, or substitute staff member or volunteer in, the child care agency to report child abuse or neglect as required by Tennessee Code Annotated, Sections 37-1-403 and 37-1-605.
 - 4. Because the statutory requirements of Tennessee Code Annotated, Sections 37-1-403 and 37-1-605 do not authorize the prohibited procedures described in

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parts 2-3 of this subparagraph (c) regarding the statutory duty of any person, and especially the duty of those licensed by the State of Tennessee to care for and protect vulnerable children, to make timely and effective reports of child abuse and neglect to appropriate investigative agencies, and because the prohibited procedures described in parts 2-3 of this subparagraph (c) are completely unreliable procedures to ensure that the appropriate authorities are able to timely and satisfactorily investigate suspected child abuse or neglect, any action that does not comply in all respects with subparagraph (a) above, will not fulfill the statutory duty to report child abuse or neglect and the licensing requirements of this Chapter.

5. Failure to Report Properly Is Grounds for Suspension, Denial or Revocation of the Agency License.
 - (i) Failure to make the reports required by subparagraph (a) above or the use of the prohibited methods described in parts 1-3 of this subparagraph (c) as an attempt to fulfill the duty to report suspected child abuse or neglect, for children in the care of the child care agency are, by themselves, grounds for suspension, denial or revocation of the agency's license.
 - (ii) If the facts establish by a preponderance of the evidence that there has not been strict compliance with the requirements of subparagraph (a) above or that the prohibited procedures described in parts 1-3 of this subparagraph (c) have been utilized as an alternative means of fulfilling the requirements of subparagraph (a) above, these circumstances shall create a rebuttable presumption for the Administrative Law Judge and the Child Care Agency Board of Review that the duty to report child abuse or neglect has not been fulfilled, and this ground for suspension, denial, or revocation of the agency's license by the Department of Human Services shall be sustained unless such presumption is rebutted by a preponderance of the evidence.
- (d) All agency staff, including non-caregiving staff, shall receive training every six (6) months on how to report child abuse and neglect.
- (e) Agency Duties During Investigations of Child Abuse and Neglect; Custodial Authority of Children.
 1. Every operator, owner, licensee, director, or staff member of, or substitute staff member or volunteer in, a child care agency licensed by the Department of Human Services shall fully cooperate with all agencies involved in the investigation of child abuse or neglect, and with the Department of Human Services in efforts to provide protection for children enrolled in the child care agency.
 2. The agency shall provide access to records of children and staff.
 3. The agency shall allow appropriate investigators to interview children and staff.
 4. The agency shall not interfere with a child abuse and neglect investigation.
 5. The agency shall protect the child by requesting the investigator's identification.
 6. The agency shall maintain confidentiality of the investigation and shall not disclose the investigation or details of the investigation except as required to carry out

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procedures for the protection of children or as otherwise directed by the Department of Children's Services, law enforcement or the Department of Human Services.

- (f) Upon notification of a pending abuse/neglect investigation of any agency staff member or resident of a home-based center, the agency shall enter into a Safety Plan with the Department regarding the individual's access to the agency and to children in the care of the agency.
- (19) A parent/guardian shall be notified before the child leaves the premises except in emergency circumstances, except that an authorized investigator with the Department of Children's Services or local law enforcement may take a child off the premises of the agency if he/she has obtained custody of the child through or as follows:
 - (1) Voluntary placement agreement with the parent;
 - (2) Court order, or;
 - (3) Emergency assumption of custody under T.C.A. §37-1-113 without parental permission, or;
 - (4) If the child's parent or legal guardian is present and approves, or;
 - (5) In conjunction with investigative procedures under the child abuse laws.

Authority: T.C.A. §§ 4-5-201 et seq.; 71-1-105(12); 71-3-501 et seq.; 37-1-113; 37-1-401 et seq.; 37-1-601 et seq. 39-17-1601 et seq. and 20 U.S.C. § 6081 et seq.

1240-4-3-.11 FOOD.

- (1) Nutritional Needs.
 - (a) If the agency provides meals, the agency shall provide developmentally appropriate meals, snacks, and drinks for each child that are of sufficient proportions and nutritional value to meet each child's health needs as defined by current United States Department of Agriculture (USDA) guidelines.
 - (b) For children in care at least four (4) hours, one (1) snack shall be provided, unless the four (4) hour period covers a normal meal hour, in which case a meal shall be provided.
 - (c) Powdered milks shall be used only in a cooked food product.
 - (d) Children in care five (5) to ten (10) hours shall be provided one (1) meal (defined as meat or meat substitute, vegetable and/or fruit, bread or bread product, and milk or cheese); and one (1) or two (2) snacks.
 - (e) Children in care longer than ten (10) hours shall be provided two (2) complete meals and one (1) or two (2) snacks.
 - (f) Extended Care: For extended night care children, meal and snack service will not apply while children are asleep, but snacks will be offered if the child awakens and indicates hunger.

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- (g) Breakfast (defined as fruit, vegetable or juice; cereal or bread product; and fluid cow or soy milk) shall be offered to children who arrive before 7:00 a.m. and have not had breakfast at home.
 - (h) All special needs diets shall be prepared as prescribed by a physician or by the written instructions of the parent.
 - (i) In order for parents/guardians to be aware of the food their children are receiving the week's menus shall be planned and posted by the first day of each week and remain posted throughout the week.
 - 1. These menus shall be followed, although reasonable substitutions are permissible, if the substituted food contains the same nutrients.
 - 2. Any change shall be documented in advance of the meal.
 - (j) Food shall not be forced on or withheld from children.
 - (k) Food as Behavior Management.
 - 1. Foods served as part of the meal/supplement pattern shall not be used as reward; nor shall food be used or withheld as a form of discipline.
 - 2. Desserts and sweets shall not be used as rewards or a form of discipline.
 - (l) New foods shall be introduced to infants and toddlers one at a time over a five (5) to-seven (7) day period with parent's approval.
 - (m) The feeding schedule for infants shall be in accordance with the child's need rather than according to the hour.
 - (n) Staff shall support and facilitate a parent's decision to continue breast feeding.
 - (o) Appropriate foods shall be encouraged; highly inappropriate foods, e.g. foods high in sugar and/ or fat content but containing low nutritional value, shall be discouraged.
 - (p) Parents and caregivers shall work together when weaning an infant to insure consistency in the weaning process. Weaning shall be delayed until after an infant adjusts to group care.
 - (q) Children shall not be permitted to carry a bottle with them throughout the day.
- (2) Meal Service.
- (a) Caregivers and children shall wash their hands according to prescribed handwashing techniques.
 - (b) High chairs and tables on which food is prepared and served shall be washed with soap and water and sanitized prior to and after snacks and meals.
 - (c) Floors under tables and high chairs on which food is served shall be swept and/or vacuumed after each meal and cleaned as needed.

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- (d) Dishes and Utensils.
 - 1. Napkins, individual forks and/or spoons shall be provided for children who feed themselves.
 - 2. Individual dishes as necessary for the type of feeding shall be provided.
 - 3. Routine food service dishes, utensils, and bottles shall be break-resistant.
- (e) Due to the extreme risk of choking, solid foods (including cereal) shall not be given in bottles or with infant feeders to children with normal eating abilities unless authorized by a physician. Violation of this rule may result in suspension, revocation or denial of the agency's ability under its license to provide infant care.
- (f) To avoid choking, foods shall be appropriate for the eating and chewing abilities of children. Hotdogs, if served to preschool children, shall be finely chopped or quartered lengthwise because they swell if trapped in a child's throat.
- (g) At mealtime, children shall be seated at appropriately-sized tables and chairs, and adults shall sit with them.
- (h) Formula and Food Brought From Home:
 - 1. All formulas and food brought from home shall be labeled with the child's name.
 - 2. Milk shall be placed immediately in the refrigerator.
 - 3. Once milk has been warmed, it shall not be re-warmed or returned to the refrigerator.
 - 4. For optimum digestion, formula is to be served at body temperature.
 - 5. Frozen breast milk shall be dated when expressed.
 - 6. All formulas remaining in bottles after feeding shall be discarded.
- (i) Microwaves, Bottle Warmers, and Crock Pots. In order to prevent scald and splash burns:
 - 1. Microwave ovens, bottle warming devices, and crock pots, including cords, shall not be accessible to preschool children.
 - 2. School-age children shall use microwaves only under direct supervision.
 - 3. Children shall never be held while removing a bottle from a crock pot or warming device.
 - 4. The "splash zone" area immediately surrounding microwaves, crock pots and warming devices shall be kept inaccessible to children at all times.
 - 5. All crock pots, bottle warmers and other warming devices shall be maintained at the device's lowest available temperature setting.

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6. Crock pots and bottle warming devices shall be secured in such a manner as to prevent them from tipping over, splashing or spilling.
 7. Bottled breast milk, infant bottles, and formula shall not be heated in a microwave oven.
 8. To prevent scalding, liquid and solid foods heated in a microwave shall be carefully checked for "hot spots" prior to serving.
- (g) Previously opened baby food jars shall not be accepted in the center. If food is fed directly from the jar by the caregiver, the jar shall be used for only one feeding.
 - (h) Infants shall be held while being fed as long as they are unable to sit in a high chair, an infant seat, or at the table.
 - (i) To avoid the risk of serious injury or choking children shall always be restrained in the high chair manufacturer's restraint device while sitting in a high chair. Children who are too small or are too large to be restrained using the manufacturer's restraint device shall not be placed in a high chair.
 - (j) Bottles shall not be propped, and a child shall not be given a bottle while lying flat.
 - (k) When children are capable of using a high chair, they shall be allowed to do so and to experiment with food, with feeding themselves, and to eat with fingers or spoon.
 - (l) Children shall never be left without adult supervision while eating.

Authority: T.C.A. §§ 4-5-201 et seq.; 71-1-105(12); 71-3-501 et seq.

1240-4-3-.12 PHYSICAL FACILITIES.

- (1) Inspections and Compliance with Fire, Health and Safety Standards.
 - (a) Facilities that:
 1. Are currently unlicensed;
 2. Have not previously been approved by the State Fire Marshall;
 3. Have relocated; and/or
 4. Existing facilities with renovations, new construction, additions to, and /or changes in occupancy, each shall:
 - (b) Comply with the standards and requirements of:
 1. The State Fire Marshall's division of the Tennessee Department of Commerce and Insurance; and
 2. The Food and General Sanitation Division of the Tennessee Department of Health.
- (2) Fire safety requirements and environmental standards shall be met before a temporary or annual license can be issued.

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- (3) Requests for inspections shall be made by the Department, but it is the responsibility of the applicant to obtain verification of the inspections and the approvals.
- (4) Building Plans: Plans for new construction must be drawn by a registered architect or engineer and submitted to the State Fire Marshall and to the local health department when required by such departments and in accordance with the respective departments' procedures.
- (5) Continuing compliance. Physical facilities shall maintain compliance with all applicable codes as set forth in paragraph (1), above, throughout the licensing year, and shall additionally comply with any updated standards issued by the Department of Health and the State Fire Marshal.
- (6) Annual inspection. All facilities shall be inspected and approved annually by either state codes enforcement officers or authorized local fire safety inspectors and by environmentalists.
- (7) The agency shall not be located in a building used for purposes which would be hazardous to the children or would prohibit outdoor play unless the agency is an inner city agency which has requested and been granted an exception from the Department pursuant to the requirements for "Outdoor Play" found in subchapter 1240-4-3-.09 of this Chapter.
- (8) Telephones and Other Communication Devices.
 - (a) Due to the potential unreliability of cellular phones and the potential failure of cordless phones during power outages in an emergency at least one (1) working, land-line telephone shall be present in the agency.
 - (b) If answering machines/voice mail must be used, they shall be monitored at thirty (30) minute intervals (except when staff and children are off premises) so that emergency messages can be received.
 - (c) Parents/guardians shall be informed that answering machines/voice mail are used.
- (9) Licensed Capacity of Physical Space.
 - (a) The maximum number of children who may be present inside a physical space (e.g., the agency's "licensed capacity") shall be determined in accordance with the minimum square footages set forth in this paragraph; provided, however, that the Department may, in its discretion as determined reasonably necessary to maintain the health and safety of the children in care, restrict the agency's licensed capacity under the maximum set forth in these rules.
 - (b) A minimum of thirty (30) square feet of usable indoor play space must be provided for each child.
 - (c) Each naproom must contain a minimum thirty (30) square feet of floor space per child.
 - (d) Teen parenting vocational classes shall have separate space for the group of young children with thirty-five (35) square feet of usable play space per child that is apart from the classroom space for students.
 - (e) Occupational/vocational child care classes shall have separate space for the group of young children, with thirty-five (35) square feet per child of usable space, apart from the classroom space for students. The designated separate space may be located in the same room and divided by movable barriers less than four feet (4') in height.

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- (f) For the purposes of calculation of square footage requirements, any area used as restrooms, halls, kitchen, or office space, and any space used by cribs or large pieces of furniture, shall not be considered “usable indoor play space” and shall not be counted toward the agency’s licensed capacity.
 - (g) Rooms with sufficient floor space, as based upon the requirements set forth in these rules, may be divided and used for more than one (1) group; provided, however, that each area is adequately equipped and arranged and that each group shall have the security of a stable classroom space.
- (10) Outdoor Play Area.
- (a) Outdoor play areas shall contain a minimum of fifty (50) square feet of usable play space for each child using the area at one time.
 - (b) Agencies Initially Licensed After January 1, 2002: The outdoor play area must be enclosed by a fence or barricade at least four feet (4’) in height; provided, however, that the agency may request that the Department, in its discretion, waive such requirement upon a clear showing that the the lack of such fence or barricade poses no apparent or potential risk to children.
 - (c) The areas where children play or are cared for shall be properly maintained:
 - 1. A written playground maintenance plan shall be prepared by the agency to address routine, remedial, and preventive maintenance and to designate who is responsible for each maintenance need.
 - 2. A pre-play/care inspection shall be done by the agency before children play outdoors.
 - 3. The play/care areas shall be free of hazardous items or materials unless adequately protected by storage, inaccessibility, proper supervision, or other safety procedures.
 - 4. These play/care areas shall otherwise present no conditions which may be hazardous to children.
 - 5. All such play/care areas shall be free of all animal wastes.
- (11) Equipment Hazards
- 1. Cords on window blinds shall be inaccessible to children.
 - 2. Electrical cords on equipment shall be inaccessible to the children.

Authority: *T.C.A. §§ 4-5-201 et seq.; 71-1-105(12); 71-3-501 et seq.*

1240-4-3-.13 TRANSPORTATION.

- (1) Management Responsibility.
 - (a) Prior to offering child care transportation services of any type, directly or by contract, all new and existing child care agencies must provide written notice to the Department.

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- (b) Unless specifically noted otherwise within the context of the rule, the agency is responsible for compliance with all transportation provisions of this subchapter, regardless of whether the agency provides transportation directly, through a third party by contract or otherwise.
 - (c) The child care agency's management shall be fully responsible for the transportation of children between the child's home and the agency, to or from school, and/or on field trips on any vehicle which it operates, for which it contracts or which is otherwise under its direction or control.
 - (d) Prior to providing transportation services of any type all existing and new child care agencies must provide a written statement to the Department describing:
 - 1. The type(s) of transportation that will be offered, e.g., from the child's home to the child care agency, from the child care agency to the child's school, etc.;
 - 2. A list and description of the vehicles that will be used for the transportation of children; for example, "2002 small white school bus";
 - 3. A description of any contracts, agreements or arrangements with any third (3rd) parties for the provision of transportation services;
 - 4. The agency's plan for maintaining compliance with the transportation time limits set forth in this Chapter;
 - 5. The agency's policy, procedures and staff training plans for maintaining compliance with the responsibilities for loading, unloading, and tracking each child as set forth in this Chapter;
 - 6. The agency's management plan for ensuring all transportation staff properly perform their duties in accordance with the licensing rules and agency policies and procedures.
 - 7. The agency's policy, procedures and staff training plans for attaining and maintaining compliance with all applicable child safety restraint requirements as set forth in these rules and state law;
 - 8. The provider's policy, procedures and staff training plans for the emergency evacuation of the vehicle.
 - (d) Vehicles used to transport children and which are owned or operated by, contracted for or which are otherwise under the direction or control of the child care agency, shall carry automobile liability insurance coverage for each vehicle used for that purpose in the minimum amounts required by this Chapter.
- (2) Supervision of Children During Transportation.
- (a) An adult must be in the vehicle whenever a child is in the vehicle.
 - (b) Adult Monitor Requirements.
 - 1. An adult monitor, in addition to the driver, is required on the vehicle for the transportation of four (4) or more children ages six (6) weeks through five (5) years of age, who are not in kindergarten;
 - 2. An adult monitor, in addition to the driver, is required on the vehicle for all routes exceeding thirty (30) minutes for children ages six (6) weeks through five (5) years of age, who are not in kindergarten, regardless of the total number of children being transported.

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3. An adult monitor, in addition to the driver, is required on the vehicle for the transportation of four (4) or more non-ambulatory children (permanent or temporary) of any age.
- (3) Responsibility for Loading, Unloading and Tracking Each Child.
- (a) Passenger Log:
 1. A passenger log provided by, or in a format approved by, the Department shall be used to track each child during transportation.
 2. The name of each child received for transport shall be recorded on the passenger log.
 3. The driver of the vehicle or the monitor shall be designated by management as the person responsible for completing the log.
 4. Each child shall be separately listed by first and last name. A sibling group shall not be listed as a group entry.
 - (b) Loading Procedures:
 1. As each child is loaded onto the vehicle the time the child was placed on the vehicle shall be recorded onto the passenger log by the person designated to keep the log.
 2. If the child was loaded from home, the parent or other authorized person will additionally sign the log indicating that the child was placed on the vehicle.
 - (c) Unloading Procedures:
 1. The individual designated by the agency as responsible for the log shall update it immediately upon the child being released from the vehicle. The log shall be updated by the designated staff member:
 - (i) Recording the time the child was released; and
 - (ii) Initialing next to the time of release.
 2. When the child is released to a parent or other authorized person, that person must sign the log indicating that the child was released to them.
 - (d) Confirming that Every Child Is Off of the Vehicle
 1. Driver Responsibilities:
 - (i) Immediately upon unloading the last child and to ensure that all children have been unloaded the driver shall:
 - (I) Physically walk through the vehicle; and
 - (II) Inspect all seat surfaces, under all seats and in all compartments or recesses in the vehicle's interior; and
 - (III) Sign the log, with the driver's full name, indicating the children are all unloaded; and

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- (IV) Give the passenger log to the monitor, or to the additional reviewer if no monitor is required.

2. Monitor Responsibilities:

- (i) If a monitor was also on the vehicle the monitor shall:
 - (I) Physically walk through the vehicle; and
 - (II) Inspect all seat surfaces, under all seats and in all compartments or recesses in the vehicle's interior; and
 - (III) Sign the log with the monitor's full name indicating the children are all unloaded.
- (IV) If the monitor has been designated by the agency as responsible for keeping the log, the monitor must also give the log to the additional reviewer as set forth below.

3. Additional Reviewer Responsibilities:

- (i) Agency management shall designate an additional person, who did not ride on the vehicle, to conduct an inspection once the vehicle has been unloaded.
- (ii) The additional reviewer shall:
 - (I) Physically walk through the vehicle; and
 - (II) Inspect all seat surfaces, under all seats and in all compartments or recesses in the vehicle's interior; and
 - (III) Sign the log with the additional reviewer's full name to indicate all children are unloaded;
 - (IV) Reconcile the passenger log with the agency's attendance roll; and
 - (V) Immediately notify the director or other individual designated in charge of any discrepancies between the passenger log and the attendance roll.

4. Loading/Unloading Children at School.

- (i) When children are transported to school, they shall be released in accordance with the following procedures:
 - (I) Children shall be unloaded only at the location designated by the school;
 - (II) Children shall only be unloaded from the agency's vehicle at the time the school is open to receive them;
 - (III) The driver/monitor shall watch the children who are unloaded from the vehicle walk through the entrance door designated by the school for the children; and
 - (IV) Any additional procedures established by the school.

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- (ii) When children are picked up from school they shall be loaded on the vehicle at the location designated by the school.
- (iii) The child care agency shall develop written policy approved by the Department that:
 - (I) Contains written procedures for the driver to follow in the event that a child scheduled to be picked up does not report to the vehicle; and
 - (II) Insure that children will have adult supervision should the driver need to try to locate a missing child.

5. Vehicle Monitoring Devices

- 1. All vehicles used by or on behalf of the agency for transportation of children, that are designed to transport six (6) or more passengers must be equipped with a child safety monitoring device approved by the Department which prompts staff to inspect the vehicle for children before an alarm sounds; provided, however, that such device shall not be required:
 - (i) On vehicles in which all the children being transported are five (5) years of age and in kindergarten, or older, unless any of the children are developmentally or physically disabled or non-ambulatory, or
 - (ii) On vehicles used exclusively for occasional field trips.
- 2. Only devices approved by the Department are authorized for use on such a vehicle.

(4) Transportation Staff Qualifications.

- (a) All drivers and monitors (through contract or otherwise), shall comply with all applicable transportation staff qualifications set forth in this paragraph.
- (b) Documentation of all transportation staff qualifications shall be kept on file at the agency and be available to the Department upon request.
- (c) Drivers License. At a minimum, a current Tennessee driver license with "F" endorsement ("for hire") or an equivalent endorsement recognized by the Department of Safety as meeting the minimum qualifications for transportation of children enrolled in child care agency in the applicable vehicle.
- (d) Department of Safety Driver Requirements.
 - 1. Persons transporting children for a child care agency shall have available for review by the Department of Human Services documentation of any training and testing required and provided by the Department of Safety
 - 2. All persons subject to this paragraph shall obtain a certification document from the Department of Safety to signify that they have passed additional written or skills tests required for persons who may, in the course of their duties drive a vehicle that transports children enrolled in a child care agency.
 - 3. All persons subject to this paragraph shall be required to obtain annual training that is utilized for school bus drivers offered by the Department of Safety or such other equivalent training as the Department of Safety may determine is appropriate.

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- (e) Health Examinations for Drivers: The agency shall maintain documentation, signed by the examining licensed physician, licensed psychologist, licensed clinician, Nurse Practitioner or Physician's Assistant, verifying that the individual is a physically, mentally and emotionally capable of safely and appropriately providing transportation for children.
- (f) Drug Screenings for Drivers.
 - 1. Individuals shall pass a drug screening test in accordance with procedures set by the Department:
 - (i) Prior to the individual being employed full or part-time as a driver (contract or otherwise) who provides transportation services for compensation on behalf of the agency; or
 - (ii) Prior to an existing employee (contract or otherwise) assuming driving duties, at any time
 - 2. The child care agency management shall immediately review the results of the drug screen upon receipt.
 - 3. Upon receipt of a positive drug screen result or upon receipt of notification by a contractor or other person or entity providing transportation for compensation, the child care agency shall immediately:
 - (i) Notify the Department and prohibit the individual from any duties involving any children enrolled in the child care agency; and
 - (ii) Enter into a safety plan approved by the Department that excludes the individual from driving for the child care agency until the individual passes a drug screen test and is otherwise approved, in writing, by the Department, to provide driving duties involving the transportation of children for the child care agency.
 - 4. The agency shall be responsible for verifying that a contractor, or other person or entity providing transportation for compensation to the child care agency has not employed or assigned any driving duties for the agency to any individual who fails to pass a drug screen as required by this part.
- (g) Prior to assuming their duties, all persons responsible, or who may in the course of their duties become responsible at any time for transporting children (including drivers and monitors) shall complete Department-recognized pre-service training in:
 - 1. The proper daily safety inspection of the vehicle as required by these rules;
 - 2. The proper use of child safety restraints required by these rules and state law;
 - 3. The proper loading, unloading, and tracking of children as required by these rules;
 - 4. The proper use of a blood borne pathogen kit, first aid kit, and other required vehicle emergency equipment as required by these rules;
 - 5. The proper verification procedures for the evacuation of the vehicle based upon the type of vehicle and the ages of the children served; and

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6. The developmentally appropriate practices applicable to the behavior management of children during transportation.
- (h) Following the completion of pre-service transportation training, all persons responsible at any time for the transportation of children (including drivers and monitors), shall complete the Department-recognized transportation training on transportation rules every six (6) months.
- (i) Emergency Aid Training. All persons responsible (including all drivers and monitors), or who in the course of their duties become responsible at any time, for the transportation of children shall hold current certification in:
 1. Infant/Pediatric Cardiopulmonary Resuscitation (CPR) from the American Red Cross, the American Heart Association, or other certifying organization as recognized by the Department; and
 2. A first aid course sponsored or approved by the American Red Cross, or other first aid course, as recognized by the Department.
- (j) The training requirements set forth in this paragraph do not apply to individuals who provide transportation services exclusively for occasional field trips.
- (5) Vehicle Requirements and Inspections.
 - (a) The requirements of this paragraph include vehicles used at anytime by the agency or by a contractor for the agency as the regular child care vehicle(s) and/or as back-up vehicles.
 - (b) The vehicle shall have the following equipment:
 1. Fire extinguisher,
 2. Emergency reflective triangles,
 3. First aid kit, and
 4. Blood-borne pathogenic clean-up kit.
 - (c) The driver or monitor assigned to the vehicle shall be familiar with the location and use of all equipment required under subparagraph (b) above.
 - (d) Emergency exiting procedures shall be practiced on a regular basis by all staff responsible for transporting children.
 - (e) The carrying, possession or storage of firearms or other weapons in child care vehicles is prohibited.
 - (f) The child care agency shall maintain documentation that the following daily inspections have been performed and any necessary repairs or other appropriate action taken before transporting children:
 1. A visual inspection of the vehicle's tires for wear and adequate pressure;
 2. A visual inspection for working headlights and taillights (brake lights and back-up lights), signals, mirrors, wiper blades and dash gauges;

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3. An inspection for properly functioning child and driver safety restraints;
 4. An inspection for properly functioning doors and windows;
 5. An inspection for the presence of safety equipment required by these rules or any other provisions of law or regulations, and repair or replacement as necessary based upon visual evidence of the need do so;
 6. A determination that the vehicle has adequate fuel; and
 7. An inspection for, and cleaning of, debris from the vehicle's interior.
- (g) The child care agency shall maintain documentation that the following maintenance is performed:
1. Receive regular inspections and maintenance by a certified mechanic in accordance with the maintenance schedule recommended by the vehicle manufacturer, and
 2. Have the following vehicle equipment certified as inspected at least every four thousand (4,000) miles if not covered by, and/or otherwise serviced in accordance with the manufacturer's maintenance schedule:
 - (i) Brakes;
 - (ii) Steering;
 - (iii) Oil levels, coolant, brake, windshield washer and transmission fluids;
 - (iv) Hoses and belts; and
 - (v) Tires.
- (h) Department of Safety Inspections. All child care vehicles that are designed by the vehicle manufacturer to carry ten (10) or more passengers must be inspected annually by the Department of Safety. Any maintenance or repair to the vehicles disclosed by the inspections shall be the sole responsibility of the child care agency.
- (i) No vehicle which does not pass the inspections required in this subpart shall be used by the child care agency or by its contractors, or others subject to the agency's direction and control, to provide transportation services until necessary repairs, as determined by the Department, have been made.
- (6) Child Safety Restraints.
- (a) The provisions of this paragraph apply to all transportation, including field trip transportation, provided by or on behalf of the agency.
 - (b) Children under four (4) years of age shall never be placed in the front seat of the vehicle.
 - (c) Children who weigh less than twenty pounds (20 lbs.) shall be placed to face the rear of the vehicle. Children who weigh twenty pounds (20 lbs.) or more shall be placed to face the front of the vehicle unless the special needs of a disabled child otherwise require the child to face the rear of the vehicle.

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- (d) Children who weigh less than forty pounds (40 lbs.) shall be restrained in a Federally-approved child restraint device in accordance with the child restraint device manufacturer's instructions. The child restraint device shall be secured to the vehicle in accordance with the child restraint device manufacturer's instructions.
 - (e) Children Between Forty Pounds (40 lbs.) and Eighty Pounds (80lbs.):
 - 1. May be restrained in a belt-positioning booster seat (BPBS) that has been secured in accordance with the vehicle and restraint manufacturers' instructions; or
 - 2. If a BPBS restraint device is not used, the child shall be restrained in both a lap belt and a shoulder belt; or
 - 3. If both a lap and shoulder belt restraint system is not available in the vehicle, the child shall be restrained by a lap belt.
 - 4. Effective January 1, 2007. Children in this weight range must be restrained in a belt-positioning booster seat (BPBS) in accordance with the BPBS manufacturer's instructions.
 - (f) Children Weighing More Than Eighty (80 lbs.) or Who are Taller Than Four Feet Nine Inches (4'9"):
 - 1. May be restrained in an adult lap belt and shoulder belt that has been secured in accordance with the vehicle manufacturer's instructions; or
 - 2. If an adult lap belt and shoulder belt is not used, the child shall be restrained by a lap belt.
 - 3. Effective January 1, 2007. Children in weight and size range shall be restrained in an adult lap belt and shoulder belt in accordance with the vehicle manufacturer's instructions.
 - (g) Passenger air bags shall remain turned off unless an adult or a child fifteen (15) years of age or older is riding in the front passenger seat of the vehicle.
 - (h) No child shall ride on the floor of a vehicle.
 - (i) No child shall be placed with another child in the same restraint device.
 - (j) Notwithstanding the provisions of this paragraph, until January 1, 2007, children of school-age (in kindergarten or any grade level above) shall not be required to use child restraints when being transported in school buses classified in the "large" category under the Federal Motor Vehicle Safety Standards.
- (7) Capacity Limitations and Cargo Requirements.
- (a) The total number of adults and children in vehicles used for the transportation of children enrolled in the agency shall never exceed the manufacturer's rated passenger capacity.
 - (b) All cargo, luggage or equipment of any type shall be adequately secured at all times in such manner as to protect the passengers in case of accident or emergency maneuvers.
- (8) Requirements for Child Care Transportation Vehicles Effective January 1, 2007.

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- (a) All child care vehicles that are designed to carry ten (10) or more passengers must conform to all Federal Motor Vehicle Safety Standards (FMVSS) governing either “large” school buses or “small” school buses, as applicable, in accordance with the provisions of the FMVSS described in 49 Code of Federal Regulations Part 571, or as such Part may be amended.
 - (b) All child care vehicles must have factory-installed passenger restraint anchorages and passenger restraints, including lap belts, shoulder belts, and anchorages for the proper use of BPSB and infant carrier devices.
 - (c) The requirements of this paragraph do not apply to vehicles used exclusively for the provision of occasional field trips.
- (9) Vehicle Signage Requirements.
- (a) The requirements of this paragraph are applicable to all vehicles used for the transportation of children enrolled in the agency, including vehicles operated by a contractor of the agency or vehicles operated by any other provider of services under the direction or control of the child care agency, unless specifically exempted by these rules.
 - (b) On each side of the vehicle the following information shall be displayed in a block font that is not less than one and one-half inches (1½”) in height:
 - 1. The full name of the child care agency and emergency contact number for the agency in any font or color, including the agency’s current logo and lettering scheme, which is clearly readable at a distance of fifty feet (50’) on a stationary vehicle in daylight conditions; and
 - 2. The words “Child Care Transportation Complaints” followed by the Department’s toll-free Child Care Complaint phone number in black text on a clearly contrasting background that is clearly readable at a distance of fifty feet (50’) on a stationary vehicle in daylight conditions.
 - (c) On the rear of the vehicle the following information shall be displayed:
 - 1. The full name of the child care agency and the words “Child Care Transportation Complaints” followed by the Department’s toll-free Child Care Complaint phone number in black letters in a block font not less than one inch (1”) in height on a clearly contrasting background that is clearly readable at a distance of forty feet (40’) on a stationary vehicle in daylight conditions.
 - 2. Exception: Display of the Complaint number is not required on passenger automobiles (excluding minivans) used for transportation by the child care agency with a manufacturer’s rated seating capacity of six (6) or fewer passengers.
 - (d) The vehicle signage required by these rules shall be applied to the vehicle in one of the following formats:
 - 1. Painted directly on the vehicle in accordance with the paint manufacturer’s instructions using paint recommended by the paint manufacturer as appropriate for use on a vehicle; or
 - 2. A weather-resistant sign securely fastened to the vehicle. The term “securely fastened” includes magnetic signs and signs bolted to the vehicle. The term does not include adhesives such as tape or glue unless recommended by the adhesive manufacturer as being appropriate for outdoor use on a vehicle.
 - (e) Special Requirements for Centralized Transportation.

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1. Central transportation operations or any other entity that may own or operate more than one child care agency and which may provide centralized transportation services for its child care agencies; and/or
 2. Contractors, or other transportation service providers under the direction or control of the child care agency, which may provide centralized transportation services to more than one child care agency may substitute for the name and phone number of the child care agency the full name and emergency contact number of the central operator, contractor or other transportation service providers under the direction or control of the child care agency. If the name on the vehicle does not clearly designate the agency or entity as one providing child care transportation, words such as "Child Care Transportation Vehicle" or "Child Care Transportation Services", or similar language approved by the Department, must be displayed on the vehicle in a manner that demonstrates, as determined by the Department, that the vehicle is providing child care transportation.
- (f) Exceptions to Vehicle Identification Requirements.
1. Vehicles used exclusively for the provision of field trips; and
 2. Vehicles used exclusively for the limited provision of emergency transportation, e.g., as a result of the mechanical breakdown of the regular child care vehicle.
 3. The Department may, in its discretion, waive the requirements of this paragraph for any child care agencies owned, operated, or under the direction or control of a public agency.
 4. The Department may, in its discretion, waive the requirements of this paragraph if circumstances clearly warrant such an exemption.
- (10) Limits on Time Children Are Transported/Transportation Waivers.
- (a) Children shall not spend more than forty-five (45) minutes traveling one way; provided, however, this provision is not applicable to field trips.
 - (b) If extended transportation beyond the limits in subparagraph (a) is necessary in special circumstances, or as may be required by geographic factors, an individualized plan shall be established and signed by the parent and the child care agency and approved by the Department prior to providing such transportation.

Authority: *T.C.A. §§ 4-5-201 et seq.; 71-1-105(12); 71-3-501 et seq.; 71-3-502(d)(7)(C)(iii).*

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EXTENDED CARE.

- (1) Extended care services may be offered by an agency as an additional component to conventional care services, or the agency may exclusively provide extended care services.
- (2) In order to facilitate the availability of child care services during extended care hours while ensuring the health, safety and welfare of children during such hours any agency which is licensed to provide child care services during extended care hours shall comply with the following "Extended Care" rules in addition to the rules otherwise contained in this chapter:
 - (a) Definitions contained in 1240-4-3-.02(22).
 - (b) Supervision as required in 1240-4-3-.06(3)(d), adult:child ratios

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- (c) Program 1240-4-3-.09.
 - 1. Schedule and Routines, (1)(k);
 - 2. Television, Videos and Computers, (2)(e);
 - 3. Reclining Rest Period, (4)(a); and
 - 4. Extended care, (6);
- (d) Health and Safety, 1240-4-3-.10.
 - 1. First Aid (8)(9);
 - 2. Emergency treatment (9)(a);
 - 3. CPR (9)(c);
 - 4. Emergency drills(10)(b); and
 - 5. Program Educational Activities, (7);
- (e) Food, 1240-4-3-.11—Meals and Snacks (1)(f).

Authority: *T.C.A. §§ 4-5-201 et seq.; 71-1-105(12); 71-3-501 et seq.*

1240-4-3-.15 CARE OF CHILDREN WITH SPECIAL NEEDS.

- (1) When children with disabilities are enrolled, all reasonable and appropriate efforts shall be made to provide each child an equal opportunity to participate in the same program activities as their peers.
- (2) Parents/guardians or other appropriate individual identified by the parent shall provide information and, as appropriate, training for caregivers regarding special needs/techniques/emergency measures/etc., as utilized in the child's home to ensure the child's safety and well-being.
- (3) Adaptations to the environment shall be directed toward normalizing the lifestyle of the child by helping the child to become independent and develop self-help skills.
- (4) Behavior management techniques or program activities which would tend to demean or isolate the child are prohibited.
- (5) The agency shall inform parents/guardians of any specialized services available from the agency, and if the agency is aware of any specialized services available through third parties, shall additionally -inform the parent/guardian of such services.
- (6) Efforts to provide specialized services (e.g., speech/hearing therapy, physical therapy, psychological evaluation, or services for the mentally retarded) either directly or by referral, shall be conducted only with written permission by the parent/guardian and documented in the child's record. Any information exchange regarding these services that is shared with or received from third parties shall also be documented.

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- (7) Emergency Plans.
 - (a) The agency shall have written individualized emergency plans for each disabled child who requires more assistance in emergencies than other children of the same age or in the same group.
 - (b) The emergency plan shall be approved by the Department.
 - (c) The agency shall maintain documentation that the Emergency Plan is practiced monthly.
- (8) Each non-verbal child's daily activities, including, as applicable to the individual child, the time and amount of feeding, elimination, times of diaper changes, sleep patterns, and developmental progress, shall be recorded and shared with the parents/guardians daily.
- (9) Diapering of School-Age Children with special needs shall be completed as required by Rule 1240-4-3-.10.

Authority: *T.C.A. §§ 4-5-201 et seq.; 71-1-105(12); 71-3-501 et seq.*

1240-4-3-.16 SICK CHILD CARE.

- (1) Scope of services. Agencies that provide sick child care as either an exclusive service or as a component of an existing child care service must, in addition to the rules contained in this chapter, comply with the rules contained in this subchapter 1240-4-3-.16. Any conflict between the provisions of subchapter 1240-4-3-.16 and subchapters 1240-4-3-.01 through 1240-4-3-.15, inclusive, shall be resolved in favor of the requirements contained in subchapter 1240-4-3-.16.
- (2) Statement of Agency Services, Policies and Procedures.
 - (a) An applicant for a license to operate a child care agency providing sick child care services shall submit a written statement to the Department, in the form and manner directed by the Department, which provides the following information:
 - 1. If sick child care services will be operated in the same facility as non-sick child care, the child care agency's provisions for maintaining the physical and operational separation of the sick child care and non-sick child care services;
 - 2. A description of the types of sick care child care services that are to be offered to children and, as applicable, to parents/family;
 - 3. Ages of children to be served;
 - 4. Types of illnesses/symptoms that will be served and types that will be excluded;
 - 5. Admission requirements and enrollment procedures not included in the agency's Statement of Purpose as required by 1240-4-3-.05;
 - 6. Hours of operation;
 - 7. Plans for feeding children as appropriate to each child's age and illness;

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8. Procedures for cleaning, sanitizing and infection control;
 9. Staff training plan;
 10. Methods of daily care including record keeping, reports;
 11. Policy, procedures, and staff training plan for emergency medical care; and
 12. Procedures for staff communication with parent and health care providers
- (b) After being licensed, if a licensee wishes to change the scope or type of service offered to children and families, an amended statement shall be filed with the Department for approval prior to implementation.
- (3) Medical Protocols
- (a) The sick care agency management shall develop a medical protocol for specific illnesses in accordance with best practices and the requirements of these rules and otherwise review agency policies. Medical protocol and policies shall be developed in consultation with a licensed family, internal medicine or pediatric physician, or a licensed nurse practitioner/clinician with specialization in family or pediatric medicine.
- (b) The physician or nurse must review and provide an updated, signed, approval of such protocols every six (6) months. In addition, the physician or nurse must otherwise be available on an ongoing basis for medical consultation.
- (4) Admission and Enrollment Requirements.
- (a) Children must be at least three (3) months of age and no more than twelve (12) years of age for admission to the sick child care agency.
- (b) Children between the ages of three (3) months and six (6) months with a fever of one hundred one (101) degrees Fahrenheit shall not be admitted until a written statement is provided from a licensed physician or nurse practitioner/clinician which states that it is acceptable for the infant to attend the sick child care agency.
- (c) Children with any of the following symptoms shall not be accepted for care:
1. Temperature greater than one hundred three degrees (103°) Fahrenheit and unresponsive to medication;
 2. Neck pain or stiffness;
 3. Exhibiting confusion;
 4. Unequal pupils;
 5. Dehydration;
 6. Non-clear eye discharge;
 7. Untreated TB;

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8. Excessive, persistent crying;
 9. Head trauma with vomiting;
 9. Severe or persistent pain;
 10. Contagious stages of pertussis, measles, mumps, rubella, diphtheria, chicken pox, mumps, hep B (unless isolated from other children in a contagious room with its own exterior entrance and ventilation system. Children with chicken pox and mumps shall not be cared for simultaneously in the same contagious room.);
 11. Untreated lice, scabies, pinworm, ringworm unless the child can be isolated from other children;
 12. Rapid or labored breathing;
 13. Undiagnosed rash;
 14. Persistent vomiting and/or severe diarrhea; and
 15. Other conditions as determined by the nurse or medical consultant
- (d) All children shall be evaluated by the Registered Nurse prior to admission and upon arrival each day.
- (6) Children's Records.
- (a) The records required by this paragraph shall be maintained in an organized manner on-site at the center and made available to the Department upon request.
 - (b) A care plan shall be developed and updated daily for each child. The care plan shall be completed with the assistance of the child's parent/guardian and shall be verified by the parent's signature and date on the plan.
 - (c) A chart shall be maintained for each sick child in care.
 - (d) The following records must be obtained prior to enrolling the child and must additionally be updated annually, or as changes occur:
 1. A current information form which includes the child's name, date of birth, name of parent, child's and parents' home address, parents' business address, phone numbers, work hours, social history, and the name and address (home and business or school) of a responsible person to contact in an emergency if parent cannot be located promptly. This information shall be updated annually, or as changes occur;
 2. Name, address, and telephone number of a physician to call in case of an emergency;
 3. Written consent of parent regarding emergency medical care;
 4. A child release plan stating to whom the child shall be released and procedures for allowing the refusal to release children to anyone whose behavior may place the children at immediate risk;

RULEMAKING HEARINGS

5. Daily attendance records for each child to include time in and time out;
 6. Child's care plan;
 7. Physical assessment;
 8. History of illness;
 9. Admission form;
 10. Medication permission form;
 11. Immunization record; and
 12. Daily health record, including activities, vital signs, intake, output, administration of medication
- (7) Staff.
- (a) A Registered Nurse with at least one (1) year of pediatric experience shall be present at all times sick children are in care.
 - (b) In agencies that exclusively provide sick child care, the director shall not be required to meet the provisions set forth in 1240-4-3-.07 if:
 1. The director holds a BSN; and
 2. At least one (1) full-time caregiver has a minimum of four (4) years of experience in early childhood and/or education.
 - (c) At least fifty percent (50%) of caregivers shall have Certified Nurse Assistant certificate or equivalent credential as recognized by the Department, and fifty percent (50%) shall have at least one (1) year experience in early care and/or education. One (1) caregiver may satisfy both requirements.
 - (d) All staff must have current pediatric CPR and First Aid certification.
 - (e) Within the first two (2) weeks of employment all staff shall receive training in the following areas:
 1. General infection control procedures, including handwashing, handling of contaminated items/universal precautions, use of sanitizers, food handling, washing and disinfecting toys;
 2. Care of children with common mild childhood illnesses;
 3. Recognition and documentation of illness signs and symptoms;
 4. Temperature-taking;
 5. Nutrition for ill children;
 6. Communication with parents of ill children;

RULEMAKING HEARINGS

7. When and how to call for medical assistance;
 8. Notification of local public health Department of communicable diseases;
 9. Emergency Procedures, and;
 10. Child development activities for children who are ill.
- (f) Each director and staff member shall have at least three (3) clock hours of continuing education annually which is recognized by the Department and relates to the care of ill children and the prevention and control of communicable disease.
- (7) Grouping of Adults and Children.
- (a) The following adult:child ratios and maximum group sizes shall be maintained at all times.
1. Children three (3) months through twenty-three (23) months

Ratio	Maximum Group Size
1:3	9
 2. Children twenty-four (24) months to twelve (12) years

Ratio	Maximum Group Size
1:4	12
- (b) In a multi-age grouping the adult:child ratio and maximum group size shall be determined based upon the requirement for the youngest aged child in the group. Exception: Children under sixteen (16) months may not be grouped with children age three (3) years and above.
- (c) Children shall additionally be grouped based upon the type of illness:
1. Children with respiratory illnesses, gastrointestinal illnesses and non-infectious illnesses shall be cared for in a separate room from each other; and
 2. Children shall otherwise be separated in accordance with the agency's medical protocols.
- (d) Children and staff who begin their day in a sick child care center shall remain there throughout the day and shall not be permitted to return to any other part of the child care center or any other child care center.
- (e) Staff must not care for well children on the same day they care for sick children.
- (f) Staff caring for sick children must not prepare food for well children or enter the kitchen used to prepare food for well children.
- (5) Equipment.

RULEMAKING HEARINGS

- (a) Furnishings, objects, and equipment must be maintained in good repair, and cleaned and sanitized daily and as needed.
 - (b) Separate rest equipment shall be available to each child in attendance.
- (6) Program.
 - (a) The licensee shall develop, maintain, and implement a written plan to ensure the provision of a variety of indoor activities designed to meet the needs of mildly ill children. Such activities shall include but are not limited to:
 - 1. Quiet and active play;
 - 2. Rest and relaxation;
 - 3. Eating;
 - 4. Toileting;
 - 5. Individual attention; and
 - 6. Children being comforted by care providers.
 - (b) Outdoor play is prohibited.
 - (c) Transportation is prohibited.
 - (d) Children shall be allowed to rest/nap as desired. Children shall have access at all times to rest/nap areas without distraction or disturbance from other activities.
 - (e) Drinking water and other fluids consistent with the child's condition shall be available at all times.
 - (f) All medications shall be kept locked and the key available only to personnel authorized to administer medication.
- (7) Infection Control.
 - (a) Only disposable diapers shall be used.
 - (b) Diapering practices outlined in subchapter 1240-4-3-.10 shall be followed.
 - (c) Drinking fountains are prohibited.
 - (d) If meals and snacks are served, disposable cups, plates, utensils, and napkins shall be used.
 - (e) Only liquid soap from a dispenser is allowed
 - (f) Carpet is prohibited.
 - (g) Walls and floors in rooms where sick care is provided and all linens, furnishings objects, and equipment used by or with sick children must be cleaned and disinfected at least daily and as needed.

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- (h) Toys handled by a child shall be cleaned with soap and water, then sanitized before handling by another child.
 - (i) All handled toys shall be sanitized at the end of each day.
 - (j) Non-washable toys shall not be provided. If such toys are brought from home they must be limited to personal use articles that are not shared between children.
- (8) Physical Facilities
- (a) Contagious Room.
 - 1. No child who requires separation in a contagious room may be enrolled unless authorized by the agency's medical protocols.
 - 2. The contagious room must be located in a separate room with its own entrance from the outside, and must additionally contain a separate toilet and handwashing facilities, separate toys and equipment, and a separate ventilation/air system.
 - (b) No furnishings, toys, or materials shall be shared.
 - (c) The physical space designated for sick child care shall not be used by children or staff from any other component of the center when sick children are in care.
 - (d) Rooms shall be separated by floor to ceiling wall or separate structure.
 - (e) There shall be no shared space, furnishings, fixtures, toys, supplies, or equipment if the facility serves both sick and well children.
 - (f) The use of potty chairs is prohibited.
 - (g) There shall be a minimum of fifty (50) sq. feet of usable play space per child not including cribs, large pieces of furniture, restrooms, halls kitchen, or office space. There shall be at least three (3) feet between cots/beds.
 - (h) Rest rooms, sinks for toileting/diapering and food preparation areas used for sick care must be separate from those used for well children.
 - (i) Rest rooms shall have a minimum of one (1) toilet per ten (10) children.
 - (j) Washer and dryer shall be provided on site or the licensee shall contract with a laundry service to wash smocks, linens, shoulder clothes, scrubs and other non-disposable clothing and linens.
 - (k) Rooms shall be designed to allow separate areas for resting and sleeping.
 - (l) Telephones shall be located for ready access by staff in every child care area or an intercom system shall be provided to communicate with staff.

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- (m) A program providing only sick child care shall not be required to have outdoor play space or equipment.

Authority: *T.C.A. §§ 4-5-201 et seq.; 71-1-105(12); 71-3-501 et seq.*

The notice of rulemaking set out herein was properly filed in the Department of State on the 29th day of July, 2005. (07-52)

RULEMAKING HEARINGS

DEPARTMENT OF HUMAN SERVICES - 1240

ADULT AND FAMILY SERVICES DIVISION

There will be a hearing before the Tennessee Department of Human Services to consider the promulgation repeals of rules and new rules pursuant to Tennessee Code Annotated Sections 4-5-202; 71-1-105(12) and 71-3-502. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place at the following locations:

- (1) Johnson City, Tennessee: September 19, 2005 at 6:30 p.m., Washington County Department of Human Services, 103 East Walnut Street, Conference Room, Johnson City, TN 37601;
- (2) Knoxville, Tennessee: September 20, 2005, 6:30 p.m., Knoxville State Office Building, 7th Floor, 531 Henley Street, Conference Room, A, Knoxville, TN 37902;
- (3) Chattanooga, Tennessee: September 21, 2005, 6:30 p.m., 1st Floor-Auditorium, Chattanooga State Office Building, 540 McCallie Avenue, Chattanooga, TN 37402;
- (4) Cookeville, Tennessee: September 22, 2005, 6:30 p.m. Putnam County Department of Human Services Office, 269 East South Willow, Cookeville, TN 38501;
- (5) Nashville, Tennessee: September 26, 2005, 6:30 p.m., 2nd Floor Board Room, Citizens Plaza State Office Building, 400 Deaderick Street,, Nashville, TN 37248;
- (6) Columbia, Tennessee: September 27, 2005; 6:30 p.m. Suite B, Lobby, Maury County Department of Human Services Office, 1400 College Park Drive, Columbia, TN 38401;
- (7) Jackson, Tennessee: September 28, 2005 6:30 p.m., Suite 210 Lowell Thomas State Office Building, 225 Martin Luther King Jr. Drive, Jackson, TN 38301;
- (8) Memphis, Tennessee: September 29, 2005, 6:30 p.m., Second Floor, Donnelly J. Hill State Office Building, 170 North Main Street, Memphis, TN 38103.

Any individuals with disabilities who wish to participate in these proceedings or to review these filings should contact the Department of Human Services to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date or the date the party intends to review such filings, to allow time for the Department of Human Services to determine how it may reasonably provide such aid or service. Initial contact may be made with the Department of Human Services' ADA Coordinator Fran McKinney at Citizens Plaza Building, 400 Deaderick Street, 3rd Floor, Nashville, Tennessee 37248 and telephone number (615) 313-5563 (TTY)-(800) 270-1349.

For a copy of this Notice of Rulemaking hearing, contact: Valerie Webb, Deputy General Counsel,, Department of Human Services, Citizens Bank Building, 400 Deaderick Street, 15th Floor, Nashville, Tennessee, 37248, telephone number (615) 313-2266.

RULEMAKING HEARINGS

SUBSTANCE OF PROPOSED RULES

CHAPTER 1240-4-6

REPEALS

Chapter 1240-4-6, Licensure Rules for Child Care Centers Serving School-Age Children, is repealed.

Authority: T.C.A. §§ 4-5-202; 71-1-105(12); and 71-3-502.

The notice of rulemaking hearing set out herein was properly filed in the Department of State on the 29th day of July, 2005. (07-53)

RULEMAKING HEARINGS

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT - 0800 DIVISION OF WORKERS' COMPENSATION

There will be a hearing before the Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, to consider the promulgation of rules pursuant to Tenn. Code Ann. §§ 4-5-202, 4-5-204, 50-6-204, 50-6-205 and 50-6-233. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Hearing Room, 1st Floor, Andrew Johnson Tower, 710 James Robertson Parkway, Nashville, Tennessee 37243 at 9:00 a.m. CDST on the 23rd day of September, 2005.

Any individuals with disabilities who wish to participate in these proceedings (or to review these filings) should contact the Department of Labor and Workforce Development, Division of Workers' Compensation, to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings), to allow time for the Department to determine how it may reasonably provide such aid or service. Initial contact may be made with the Department's ADA Coordinator, Mr. Jewel Crawford, at Andrew Johnson Tower, 8th Floor, 710 James Robertson Parkway, Nashville, Tennessee 37243-0655 and (615) 741-8805.

For a copy of the entire text of this notice of rulemaking hearing contact: Vickie Gregory, Administrative Assistant, Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, Andrew Johnson Tower, Second Floor, 710 James Robertson Parkway, Nashville, TN 37243-0661, (615) 253-1613.

SUBSTANCE OF PROPOSED RULES

NEW RULES

CHAPTER 0800-2-17 MEDICAL COST CONTAINMENT PROGRAM

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RULEMAKING HEARINGS

0800-2-17-.01 PURPOSE AND SCOPE

- (1) Purpose. Pursuant to Tenn. Code Ann. § 50-6-204 (Supp. 2004), the following Medical Cost Containment Program Rules, together with the Medical Fee Schedule Rules, Chapter 0800-2-18-.01 et seq., and the In-patient Hospital Fee Schedule Rules, Chapter 0800-2-19.01 et seq., are hereby adopted by the Commissioner in order to establish a comprehensive medical fee schedule and a related system which includes, but is not limited to, procedures for review of charges, enforcement procedures and appeal hearings, to implement a medical fee schedule. The Commissioner promulgates these Medical Cost Containment Program Rules together with the Medical Fee Schedule and In-patient Hospital Fee Schedule rules to establish the maximum allowable fees for health care services falling within the purview of the Tennessee Workers' Compensation Act ("Act"). These Medical Cost Containment Program Rules must be used in conjunction with the Medical Fee Schedule Rules and In-patient Hospital Fee Schedule Rules. The Medical Cost Containment Program Rules, Medical Fee Schedule Rules and In-patient Hospital Fee Schedule Rules (collectively herein "Rules") establish maximum allowable fees. Employers, carriers and providers may negotiate and contract lesser fees as are agreeable between them, but in no event shall reimbursement be in excess of the Rules, subject to the civil penalties prescribed in the Rules, as assessed by, and in the discretion of, the Commissioner, the Commissioner's designee, or an agency member appointed by the Commissioner.
- (2) Scope. These rules do all of the following:
 - (a) Establish procedures by which the employer shall furnish, or cause to be furnished to an employee who receives a personal injury, or suffers an occupational disease, arising out of and in the course of employment, reasonable and necessary medical, surgical, and hospital services and medicines, or other attendance or treatment recognized by the laws of the state as legal, when needed. The employer shall also supply to the injured employee dental services, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances necessary to cure, so far as reasonably and necessarily possible, and relieve from the effects of the injury or occupational disease.
 - (b) Establish schedules of maximum fees by a health facility or health care provider for such treatment or attendance, service, device, apparatus, or medicine.
 - (c) Establish procedures by which a health care provider shall be paid the lesser of: (1) the provider's usual charge, (2) the maximum fee established under these Rules, or (3) the MCO/PPO or any other negotiated and contracted price, where applicable. In no event shall reimbursement be in excess of these Rules. Reimbursement in excess of these Rules may, at the Commissioner's discretion, result in civil penalties of ten thousand dollars (\$10,000.00) per violation each assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, if a pattern or practice of such activity is found. At the Commissioner's discretion, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act.
 - (d) Identify utilization of health care and health services which is above the usual range of utilization for such services, based on medically accepted standards. Also to provide the ability by a carrier and the Division to obtain necessary records, medical bills, and other information concerning any health care or health service under review.

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- (e) Establish a system for the evaluation by a carrier of the appropriateness in terms of both the level of and the quality of health care and health services provided to injured employees, based upon medically accepted standards.
- (f) Authorize carriers to withhold payment from, or recover payment from, health facilities or health care providers which have made excessive charges or which have required unjustified and/or unnecessary treatment, hospitalization, or visits.
- (g) Permit review by the Division of the records and medical bills of any health facility or health care provider which has been determined not to be in compliance with these Rules, or to be requiring unjustified and/or unnecessary treatment, hospitalization or office visits.
- (h) Establish that when a health care facility or health care provider provides health care or health care service that is not usually associated with, is longer in duration than, is more frequent than, or extends over a greater number of days than the health care or service usually does with a diagnosis or condition for which the patient is being treated, the health care provider may be required by the carrier to explain the necessity in writing.
- (i) Implement the Division's review and decision responsibility. These Rules and definitions are not intended to modify the workers' compensation laws, other administrative rules of the Division, or court decisions interpreting the laws or the Division's administrative rules.
- (j) Establish maximum fees for depositions/witnesses.
- (k) Establish maximum fees for medical reports.
- (l) Provide for uniformity of billing for provider services.
- (m) Establish the effective date for implementation of these Rules.
- (n) Adopt by reference as part of this rule the American Medical Association's CPT, Medical Fee Schedule, the In-patient Hospital Fee Schedule and any amendments to the fee schedule.
- (o) Establish procedures for reporting of medical claims.
- (p) Establish procedures for preauthorization of non-emergency hospitalizations, transfers between facilities, and outpatient services.
- (q) Establish procedures for imposing and collecting civil penalties for violations of these Rules.
- (r) The Rules shall be effective July 1, 2005.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

RULEMAKING HEARINGS

0800-2-17-.02 SEVERABILITY AND PREEMPTION

If any provision of these Medical Cost Containment Program Rules, the Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules (collectively hereinafter “Rules”) or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Rules and the application of the provisions to other persons or circumstances shall not be affected in any respect whatsoever. Whenever a conflict arises between these Rules and any other rule or regulation, these Rules shall prevail.

Authority: *T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).*

0800-2-17-.03 DEFINITIONS

The following definitions are for the purposes of these Medical Cost Containment Program Rules, the Medical Fee Schedule Rules and the In-patient Hospital Fee Schedule Rules:

- (1) “Act” means Tennessee’s Workers’ Compensation Act, Tenn. Code Ann. §§ 50-6-101 et seq., as amended.
- (2) “Adjust” means that a carrier or a carrier’s agent reduces a health care provider’s request for payment such as:
 - (a) Applies the Division’s maximum fee;
 - (b) Applies an agreed upon discount to the provider’s usual charge;
 - (c) Adjusts to a reasonable amount when the maximum fee is by report;
 - (d) Recodes a procedure;
 - (e) Reduces payment as a result of utilization review.
- (3) “Administrator” means the chief administrative officer of the Workers’ Compensation Division of the Tennessee Department of Labor and Workforce Development.
- (4) “Appropriate care” means health care that is suitable for a particular person, condition, occasion, or place as determined by the Commissioner or the Commissioner’s designee after consultation with the Medical Director.
- (5) “Bill” means a request by a provider submitted to a carrier for payment for health care services provided in connection with a compensable injury, illness or occupational disease.
- (6) “Bill adjustment” means a reduction of a fee on a provider’s bill.
- (7) “BR” (By Report) means that the procedure is not assigned a maximum fee and requires a written description. The description shall be included on the bill or attached to the bill and shall include the following information, as appropriate:
 - (a) Copies of operative reports.
 - (b) Consultation reports.
 - (c) Progress notes.

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- (d) Office notes or other applicable documentation.
- (e) Description of equipment or supply (when that is the charge).
- (8) "Carrier" means any stock company, mutual company, or reciprocal or inter-insurance exchange or self-insured employer authorized to write or carry on the business of workers' compensation insurance in this state; whenever required by the context, the term 'carrier' shall be deemed to include duly qualified self-insureds or self-insured groups.
- (9) "Case" means a compensable injury, illness or occupational disease identified by the worker's name and date of injury, illness or occupational disease.
- (10) "Case record" means the complete health care record maintained by the carrier pertaining to a compensable injury, illness or occupational disease and includes the circumstances or reasons for seeking health care; the supporting facts and justification for initial and continual receipt of health care; all bills filed by a health care service provider; and actions of the carrier which relate to the payment of bills filed in connection with a compensable injury, illness or occupational disease.
- (11) "CMS" means the U.S. Centers for Medicare & Medicaid Services (formerly HCFA).
- (12) "Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development, the Commissioner's designee, or an agency member appointed by the Commissioner.
- (13) "Complete procedure" means a procedure containing a series of steps which are not to be billed separately.
- (14) "Consultant service" means; in regard to the health care of a covered injury and illness; an examination, evaluation, and opinion rendered by a health care specialist when requested by the authorized treating practitioner or by the employee; and which includes a history, examination, evaluation of treatment, and a written report. If the consulting practitioner assumes responsibility for the continuing care of the patient, subsequent service(s) cease(s) to be a consultant service.
- (15) "Compensable injury, illness or occupational disease" means an injury, illness or occupational disease for which health care treatment is mandated under Tennessee Workers' Compensation Act.
- (16) "CPT" means the most current edition of the American Medical Association's Current Procedural Terminology.
- (17) "Critical care" has the same meaning as that in the most current version of the CPT.
- (18) "Day" means a calendar day, unless otherwise designated in these Rules.
- (19) "Department" means the Tennessee Department of Labor and Workforce Development.
- (20) "Diagnostic procedure" means a service which aids in determining the nature and cause of an occupational disease or injury.
- (21) "Division" means the Workers' Compensation Division of the Tennessee Department of Labor and Workforce Development.

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- (22) "Dispute" means a disagreement between a carrier or a carrier's agent and a health care provider on the application of these Rules.
- (23) "DRG" (Diagnosis Related Group) means one of the classifications of diagnoses in which patients demonstrate similar resource consumption and length of stay patterns as for Medicare purposes by CMS (see "HCFA").
- (24) "Durable medical equipment" or "DME" is equipment which (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful to a person in the absence of illness, injury or occupational disease, and (4) is appropriate for use in the home.
- (25) "Established patient" has the same meaning as in the most current version of the CPT.
- (26) "Expendable medical supply" means a disposable article which is needed in quantity on a daily or monthly basis.
- (27) "Focused review" means the evaluation of a specific health care service or provider to establish patterns of use and dollar expenditures.
- (28) "Follow-up care" means the care which is related to the recovery from a specific procedure and which is considered part of the procedure's maximum allowable payment, but does not include care for complications.
- (29) "Follow-up days" means the days of care following a surgical procedure which are included in the procedure's maximum allowable payment, but does not include care for complications.
- (30) "Follow-up visits" means the number of office visits following a surgical procedure which is included in the procedure's maximum allowable payment, but does not include care for complications.
- (31) "HCFA" (now the "CMS") means the U.S. Centers for Medicare & Medicaid Services, formerly known as the Health Care Financing Administration of the U.S. Department of Health and Human Services.
- (32) "Health care organization" means a group of practitioners or individuals joined together to provide health care services and includes, but is not limited to, a freestanding surgical outpatient facility, health maintenance organization, an industrial or other clinic, an occupational health care center, a home health agency, a visiting nurse association, a laboratory, a medical supply company, or a community mental health center.
- (33) "Health care review" means the review of a health care case or bill, or both, by a carrier, or the carrier's agent.
- (34) "Health Care Specialist" means a board-certified practitioner, board-eligible practitioner, or a practitioner otherwise considered an expert in a particular field of health care service by virtue of education, training, and experience generally accepted by practitioners in that particular field of health care service.
- (35) "Health Care Specialist service" means, in regard to the health care of a compensable injury, illness or occupational disease, the treatment by a health care specialist, when requested by

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the treating practitioner, carrier, or by the employee, and includes a history, an examination, evaluation of medical data, treatment, and a written report.

- (36) "Inappropriate health care" means health care that is not suitable for a particular person, condition, occasion, or place as determined by the Commissioner or the Commissioner's designee after consultation with the Division's Medical Director.
- (37) "Incidental surgery" means a surgery performed through the same incision, on the same day, by the same doctor, and not related to the diagnosis.
- (38) "Independent medical examination" means an examination and evaluation conducted by a practitioner different from the practitioner providing care, other than one conducted under the Division's Medical Impairment Rating Registry (MIRR) Program.
- (39) "Independent procedure" means a procedure which may be carried out by itself, separate and apart from the total service that usually accompanies it.
- (40) "Inpatient services" mean services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds 23 hours.
- (41) "Institutional services" mean all non-physician services rendered within the institution by an agent of the institution.
- (42) "Maximum allowable payment" means the maximum fee for a procedure established by these Rules or the provider's usual and customary charge, whichever is less, except as otherwise might be specified. In no event shall reimbursement be in excess of the Division's Medical Fee Schedule. Charges in excess of the Division's Medical Fee Schedule shall, at the Commissioner's discretion, result in civil penalties of ten thousand dollars (\$10,000.00) per violation for each violation assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, whenever a pattern or practice of such activity is found. At the Commissioner's discretion, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act.
- (43) "Maximum fee" means the maximum allowable fee for a procedure established by this rule, the Medical Fee Schedule and the In-patient Hospital Fee Schedule.
- (44) "Medical admission" means any hospital admission where the primary services rendered are not surgical, psychiatric, or rehabilitative in nature.
- (45) "Medically accepted standard" means a measure which is set by a competent authority as the rule for evaluating quantity or quality of health care or health care services and which may be defined in relation to any of the following:
 - (a) Professional performance.
 - (b) Professional credentials.
 - (c) The actual or predicted effects of care.
 - (d) The range of variation from the norm.
- (46) "Medically appropriate care" means health care that is suitable for a particular person, condition, occasion, or place.

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- (47) "Medical Director" means the Division's Medical Director appointed by the Commissioner pursuant to T.C.A. § 50-6-126 (Repl. 1999)
- (48) "Medical only case" means a case which does not involve lost work time.
- (49) "Medical supply" means either a piece of durable medical equipment or an expendable medical supply.
- (50) "Modifier code" means a 2-digit number used in conjunction with the procedure code to describe unusual circumstances which arise in the treatment of an injured or ill employee.
- (51) "New patient" means a patient who is new to the provider for a particular compensable injury, illness or occupational disease and who needs to have medical and administrative records established.
- (52) "Operative report" means the practitioner's written description of the surgery and includes all of the following:
 - (a) A preoperative diagnosis.
 - (b) A postoperative diagnosis.
 - (c) A step-by-step description of the surgery.
 - (d) An identification of problems which occurred during surgery.
 - (e) The condition of the patient, when leaving the operating room, the practitioner's office, or the health care organization.
- (53) "Ophthalmologist" shall be defined according to T.C.A. § 71-4-102(3).
- (54) "Optician" shall mean a licensed dispensing optician as set forth in T.C.A. § 63-14-103.
- (55) "Optometrist" means an individual licensed to practice optometry.
- (56) "Optometry" shall be defined according to T.C.A. § 63-8-102.
- (57) "Orthotic equipment" means an orthopedic apparatus designed to support, align, prevent, correct deformities, or improve the function of a movable body part.
- (58) "Orthotist" means a person skilled in the construction and application of orthotic equipment.
- (59) "Outpatient service" means a service provided by the following, but not limited to, types of facilities: physicians' offices and clinics, hospital emergency rooms, hospital outpatient facilities, community mental health centers, outpatient psychiatric hospitals, outpatient psychiatric units, and freestanding surgical outpatient facilities also known as ambulatory surgical centers.
- (60) "Package" means a surgical procedure that includes but is not limited to all of the following components:
 - (a) The operation itself.

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- (b) Local infiltration.
 - (c) Topical anesthesia when used.
 - (d) The normal, uncomplicated follow-up care/visits. This includes a standard postoperative period of 30 days.
- (61) "Pharmacy" means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.
- (62) "Practitioner" means a person licensed, registered, or certified as an audiologist, doctor of chiropractic, doctor of dental surgery, doctor of medicine, doctor of osteopathy, doctor of podiatry, doctor of optometry, nurse, nurse anesthetist, nurse practitioner, occupational therapist, orthotist, pharmacist, physical therapist, physician's assistant, prosthetist, psychologist, or other person licensed, registered, or certified as a health care professional.
- (63) Prevailing Charge: The charge at the 50th percentile in any array of weighted customary charges made for the same geographical location. This is the upper limit of charges allowed for reimbursement of services which have no Medicare amount available and are not assigned a fee in the Tennessee Workers' Compensation Medical and In-patient Fee Schedules.
- (64) "Primary procedure" means the therapeutic procedure most closely related to the principle diagnosis.
- (65) "Procedure" means a unit of health service.
- (66) "Procedure code" means a 5-digit numerical sequence or a sequence containing an alpha or alphas and followed by three or four digits, which identifies the service performed and billed.
- (67) "Properly submitted bill" means a request by a provider for payment of health care services submitted to a carrier on the appropriate forms which are completed pursuant to this rule. Properly submitted bills shall include appropriate documentation as required by this rule.
- (68) "Prosthesis" means an artificial substitute for a missing body part.
- (69) "Prosthetist" means a person skilled in the construction and application of prosthesis.
- (70) "Provider" means a facility, health care organization, or a practitioner.
- (71) "Reasonable amount" means a payment based upon the amount generally paid in the state for a particular procedure code using data available from but not limited to the provider, the carrier, or the Tennessee Workers' Compensation Division.
- (72) "Reject" means that a carrier or a carrier's agent denies payment to a provider or denies a provider's request for reconsideration.
- (73) "Secondary procedure" means a surgical procedure which is performed to ameliorate conditions that are found to exist during the performance of a primary surgery and which is considered an independent procedure that may not be performed as a part of the primary surgery or for the existing condition.

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- (74) "Stop-Loss Payment" or "SLP" means an independent method of payment for an unusually costly or lengthy stay.
- (75) "Stop-Loss Reimbursement Factor" or "SLRF" means a factor established by the Commissioner to be used as a multiplier to establish a reimbursement amount when total hospital charges have exceeded specific stop-loss thresholds.
- (76) "Stop-Loss Threshold" or "SLT" means a threshold of charges established by the Commissioner, beyond which reimbursement is calculated by multiplying the applicable SLRF times the total charges identifying that particular threshold.
- (77) "Surgical admission" means any hospital admission where there is an operating room charge, the patient with has a surgical procedure code, or the patient has a surgical DRG as defined by the CMS.
- (78) "Transfer between facilities" means to move or remove a patient from one facility to another for a purpose related to obtaining or continuing medical care. The transfer may or may not involve a change in the admittance status of the patient, i.e., patient transported from one facility to another to obtain specific care, diagnostic testing, or other medical services not available in the facility in which the patient has been admitted. The transfer between facilities shall include costs related to transportation of patient to obtain medical care.
- (79) "Usual and customary charge" means a particular provider's average charge for a procedure to all payment sources, and includes itemized charges previously billed separately which are included in the package for that procedure as defined by these Rules.
- (80) "UB-92, HCFA-1450, 1500 or CMS-1450" means the health insurance claim form maintained by HCFA/CMS for use by institutional care providers. Currently this form is known as the UB-92.
- (81) "Wage loss case" means a case that involves the payment of wage loss compensation.
- (82) "Workers' Compensation Standard Per Diem Amount" or "SPDA" means a standardized per diem amount established for the reimbursement of hospitals for services rendered.

Authority: T.C.A. §§ 50-6-102, 50-6-204 (Supp. 2004).

0800-2-17-.04 INFORMATION PROGRAM INVOLVING RULES

The Division may institute an ongoing information program regarding these Rules for providers, carriers, employees and employers. The program may include, at a minimum, informational sessions throughout the state, as well as the distribution of appropriate information materials.

Authority: T.C.A. §§ 50-6-102, 50-6-204 (Supp. 2004).

0800-2-17-.05 PROCEDURE CODES/ADOPTION OF THE CMS' MEDICARE PROCEDURES, GUIDELINES AND AMOUNTS

- (1) Services and medical supplies must be coded with valid procedure or supply codes of the Health Care Financing Administration Common Procedure Coding System ("HCPCS").

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Procedure codes used in these rules were developed and copyrighted by the American Medical Association.

- (2) The most current edition of the American Medical Association's Current Procedural Terminology ("CPT") shall be used with these Guidelines.
- (3) Unless otherwise explicitly stated in these Rules, the most current Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and are effective upon adoption and implementation by the CMS. Whenever there is no specific fee or methodology for reimbursement set forth in these Rules, then the maximum amount of reimbursement shall be at 100% of the 2005 CMS' Medicare allowable amount. The most current effective Medicare guidelines and procedures shall be followed in arriving at the correct amount. The Medicare base amount may, upon review by the Commissioner, be adjusted upward annually based upon the annual Medicare Economic Index adjustment, but this amount shall never fall below the effective 2005 Medicare amount. Whenever there is no applicable Medicare code or methodology, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the lesser of the usual and customary or the prevailing charge amount and be billed BR.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.06 PROCEDURES FOR WHICH CODES ARE NOT LISTED

- (1) If a procedure is performed which is not listed in the Medicare Resource Based Relative Value Scale ("RBRVS"), the health care provider must use an appropriate CPT procedure code. The provider must submit an explanation, such as copies of operative reports, consultation reports, progress notes, office notes or other applicable documentation, or description of equipment or supply (when that is the charge).
- (2) The CPT contains procedure codes for unlisted procedures. These codes should only be used when there is no procedure code which accurately describes the service rendered. A special report is required as these services are reimbursed BR.
- (3) Reimbursement by the carrier for BR procedures should be based upon the carrier's review of the submitted documentation, the recommendations from the carrier's medical consultant, and the carrier's review of the prevailing charges for similar services as identified by the carrier based on data which is representative of Tennessee charges.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.07 MODIFIER CODES

- (1) Modifiers listed in the most current CPT shall be added to the procedure code when the service or procedure has been altered from the basic procedure described by the descriptor.
- (2) The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed. Reimbursement for modified services or procedures must be based on documentation of reasonableness and necessity and must be determined on a case-by-case basis.

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- (3) When Modifier 21, 22, or 25 is used, a report explaining the medical necessity of the situation must be submitted to the carrier. It is not appropriate to use Modifier 21, 22, or 25 for routine billing.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.08 TOTAL PROCEDURES BILLED SEPARATELY

Certain diagnostic procedures (neurological testing, radiology and pathology procedures, etc.) may be performed by two separate entities that also bill separately for the professional and technical components. When this occurs, the total reimbursement must not exceed the maximum medical fee schedule allowable for the 5-digit procedure code listed.

- (1) When billing for the professional component only, Modifier 26 must be added to the appropriate 5-digit procedure code.
- (2) When billing for the technical component only, Modifier TC (Technical Component) must be added to the appropriate 5-digit code.

Authority: T.C.A. §§ 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

0800-2-17-.09 INDEPENDENT MEDICAL EXAMINATION TO EVALUATE MEDICAL ASPECTS OF CASE

- (1) An independent medical examination, other than one conducted under the Division's Medical Impairment Rating Registry ("MIRR") Program, shall include a study of previous history and medical care information, diagnostic studies, diagnostic x-rays, and laboratory studies, as well as an examination and evaluation. This service may be necessary in order to make a judgment regarding the current status of the injured or ill worker, or to determine the need for further health care.
- (2) An independent medical examination, performed to evaluate the medical aspects of a case (other than one conducted under the Division's MIRR Program), shall be billed using the independent medical examination procedure code 99455 or 99456 (BR), and shall include the practitioner's time only. Time spent shall include face-to-face time with the patient, time spent reviewing records, reports and studies, and time spent preparing reports. The office visit charge is included with the code 99455 or 99456 and shall not be billed separately.
- (3) Any laboratory procedure, x-ray procedure, and any other test which is needed to establish the worker's ability to return to work shall be identified by the appropriate procedure code established by this rule and reimbursed accordingly.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.10 PAYMENT

- (1) Reimbursement for all health care services and supplies shall be the lesser of (a) the provider's usual charge, or (b) the maximum fee calculated according to these Rules (and/or any amendments to these Rules), or (c) the MCO/PPO or any other contracted price,

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wherever applicable. A licensed provider shall receive no more than the maximum allowable payment, in accordance with these Rules, for appropriate health care services rendered to a person who is entitled to health care services under the Act.

- (2) The most current Medicare RBRVS is adopted by reference as part of these Rules. The Medicare RBRVS is distributed by the Office of the Federal Register and is also available on the Internet at www.cms.hhs.gov/medicare. Whenever a different guideline or procedure is not set forth in these Rules, the most current effective Medicare guidelines and procedures shall be followed.
- (3) When extraordinary services resulting from severe head injuries, major burns, and severe neurological injuries or any injury requiring an extended period of intensive care are required, a greater fee may be allowed up to 150% of the professional service fees normally allowed under these Rules. Such cases shall be billed with modifier 21 or 22 (for CPT coded procedures) and shall contain a detailed written description of the extraordinary service rendered and the need therefore. This provision does not apply to In-patient Hospital Care facility fees which are specifically addressed in the In-patient Hospital Fee Schedule Rules, 0800-2-19-.01 et seq.
- (4) Billing for provider services shall be submitted on the forms approved by the Division: UB-92 and HFCA-1500, or their official replacement forms.
- (5) A carrier shall not make a payment for a service unless all required review activities pertaining to that service are completed.
- (6) A carrier's payment shall reflect any adjustments in the bill made through the carrier's utilization review program.
 - (a) A carrier must provide an explanation of medical benefits to a health care provider whenever the carrier's reimbursement differs from the amount billed by the provider.
 - (b) A provider shall not attempt to collect from the injured employee, employer, or carrier any amounts properly reduced by the carrier pursuant to this rule.
- (7) A carrier shall date stamp medical bills and reports upon receipt and shall pay an undisputed and properly submitted bill within thirty-one (31) calendar days of receipt. Any carrier that fails to pay an undisputed and properly submitted bill within thirty-one (31) calendar days of receipt shall be assessed a civil penalty of 2.08% monthly (25% annual percentage rate ("APR")). The 2.08% monthly civil penalty (25% APR) shall be compounded monthly and shall be payable to the provider at the time of reimbursement.
- (8) When a carrier disputes a bill or portion thereof, the carrier shall pay the undisputed portion of the bill within thirty-one (31) calendar days of receipt of a properly submitted bill. Any carrier not paying an undisputed portion of the bill within thirty-one (31) calendar days of receipt shall be assessed a civil penalty of 2.08% monthly (25% APR) on the undisputed portion of the bill. The 2.08% monthly civil penalty (25% APR) shall be compounded monthly and shall be payable to the provider at the time of reimbursement.
- (9) Any provider not receiving timely payment of the undisputed portion of the provider's bill may institute a collection action in a court having proper jurisdiction over such matters to obtain payment of the bill, together with the interest civil penalty of 25% APR. Such providers, if

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they prevail, shall also be entitled to reasonable costs and attorney fees incurred in such collection actions to be paid by the carrier or self-insured employer.

- (10) Billings not submitted on the proper form, as prescribed in these Rules, the In-patient Hospital Fee Schedule Rules, and the Medical Fee Schedule Rules, may be returned to the provider for correction and resubmission. If a carrier returns such billings, it must do so within 20 calendar days of receipt of the bill. The number of days between the date the carrier returns the billing to the provider and the date the carrier receives the corrected billing, shall not apply toward the thirty-one (31) calendar days within which the carrier is required to make payment.
- (11) Payments to providers for initial examinations and treatment authorized by the carrier or a self-insured employer shall be paid by that carrier or self-insured employer and shall not later be subject to reimbursement by the employee or another medical insurance program, even if the injury or condition for which the employee was sent to the provider is later determined non-compensable under the Act.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.11 REIMBURSEMENT FOR EMPLOYEE-PAID SERVICES

Notwithstanding any other provision of this rule, if an employee has personally paid for a health care service and at a later date a carrier is determined to be responsible for the payment, then the employee shall be fully reimbursed by the carrier.

Authority: T.C.A. §§ 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

0800-2-17-.12 RECOVERY OF PAYMENT

- (1) Nothing in this rule shall preclude the recovery of payment already made for services and bills which may later be found to have been medically paid at an amount which exceeds the maximum allowable payment. This also includes payments reimbursed to an employee pursuant to 0800-2-17-.11 above.
- (2) A carrier may recover a payment to a provider, whether by an employee or a carrier, if the carrier requests the provider for the recovery of the payment, with a statement of reasons for the request, within one year of the date of payment.
- (3) Within thirty-one (31) calendar days of receipt of the carrier's request for recovery of the payment, the provider shall do either of the following:
 - (a) If in agreement with the request, refund the payment to the carrier.
 - (b) If not in agreement with the request, supply the carrier with a written detailed statement of the reasons for its disagreement, along with a refund of the portion, if any, of the payment that the provider agrees should be refunded.
- (4) If the carrier does not accept the reason for disagreement supplied by the provider, the carrier may file a request for Administrative Review, within thirty-one (31) calendar days of receipt of the provider's statement of disagreement. The request for review shall be filed

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with the Medical Director for a recommendation by the Medical Care and Cost Containment Committee (MCCCC). The carrier shall supply a copy to the provider.

- (5) If, within 62 calendar days of the carrier's request for recovery of a payment, the carrier does not receive either a full refund of the payment or a statement of disagreement, then, at the option of the carrier, the carrier may do either or both of the following:
 - (a) File a request for Administrative Review as outlined above, of which the carrier shall supply a copy to the provider.
 - (b) Reduce the payable amount on the provider's subsequent bills (in the case in question or any other case) to the extent of the request for recovery of payment.
- (6) If, within thirty-one (31) calendar days of a recommendation from the MCCCC, a provider does not pay in full any refund recommended, the carrier may reduce the payable amount on the provider's subsequent bills to the extent of the request for recovery of payment, plus an additional 25% per annum. The carrier may, at its discretion, pursue recovery of such refund in a court of law with proper jurisdiction pursuant to T.C.A. § 50-6-226.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-226 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.13 PENALTIES FOR VIOLATIONS OF FEE SCHEDULE RULES

- (1) Providers shall not accept and employers or carriers shall not pay any amount for health care services provided for the treatment of a covered injury or illness or for any other services encompassed within the Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules. Any provider accepting and any employer or carrier paying an amount in excess of the Division's Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, shall be in violation of these Rules and may, at the Commissioner's discretion, be subject to civil penalties of ten thousand dollars (\$10,000.00) per violation for each violation, which may be assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee whenever a pattern or practice of such activity is found. At the discretion of the Commissioner, the Commissioner's Designee, or an agency member appointed by the Commissioner, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act. Any other violation of the Medical Cost Containment Program Rules, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules shall subject the violator(s) to a civil penalty of not less than one hundred dollars (\$100.00) nor more than ten thousand dollars (\$10,000.00) per violation, at the discretion of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner.
- (2) A provider, employer or carrier found to be in violation of these Rules, whether a civil penalty is assessed or not, may request a contested case hearing by requesting the hearing in writing within fifteen (15) calendar days of issuance of a Notice of Violation and, if applicable, notice of the assessment of civil penalties. If a request for hearing is not received by the Division within the fifteen (15) calendar days of issuance of the Notice of Violation, the determination of such violation shall be deemed a final order of the Department and not subject to further review.

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- (3) A request for hearing shall be made to the Division in writing by an employer, carrier or provider notified of violation of these Rules.
- (4) Any request for a hearing shall be filed with the Division within fifteen (15) calendar days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty. Failure to file a request for a hearing within fifteen (15) calendar days of the date of issuance of the Notice of Violation shall result in the decision of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner becoming a final order and not subject to further review.
- (5) The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner shall have the authority to hear the matter as a contested case and determine if any civil penalty assessed should have been assessed.
- (6) Upon receipt of a timely filed request for a hearing, the Commissioner shall issue a Notice of Hearing to all interested parties.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.14 MISSED APPOINTMENT

A provider shall not receive payment for a missed appointment unless the appointment was arranged by the Division, carrier or the employer. If the carrier or employer fails to cancel the appointment not less than one (1) business day prior to the time of the appointment, the provider may bill the carrier for the missed appointment using procedure code 99199 with a maximum fee of BR.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.15 MEDICAL REPORT OF INITIAL VISIT AND PROGRESS REPORTS FOR OTHER THAN INPATIENT HOSPITAL CARE

- (1) Except for inpatient hospital care, a provider shall furnish the carrier with a narrative medical report for the initial visit, all information pertinent to the compensable injury, illness, or occupational disease if requested within thirty (30) days after examination or treatment of the injured employee, and a progress report for every 60 days of continuous treatment for the same compensable injury, illness or occupational disease.
- (2) If the provider continues to treat an injured or ill employee for the same compensable injury, illness or occupational disease at intervals which exceed 60 calendar days, then the provider shall provide a progress report following each treatment that is at intervals exceeding 60 calendar days.
- (3) The narrative medical report of the initial visit and the progress report shall include all of the following information:
 - (a) Subjective complaints and objective findings, including interpretation of diagnostic tests.

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- (b) For the narrative medical report of the initial visit, the history of the injury, and for the progress report(s), significant history since the last submission of a progress report.
 - (c) The diagnosis.
 - (d) As of the date of the narrative medical report or progress report, the projected treatment plan, including the type, frequency, and estimated length of treatment.
 - (e) Physical limitations.
 - (f) Expected work restrictions and length of time if applicable.
- (4) Cost of the narrative medical reports required by 0800-2-17-.15(1) and (2) shall be reimbursed at the following rate: Initial and Subsequent Reports – Not to exceed \$10.00 for reports twenty (20) pages or less in length, and twenty-five (25) cents per page after the first twenty pages. Under no circumstances shall a provider bill for more than one report per visit. Initial reports shall be billed using procedure code WC101, subsequent reports shall be billed using procedure code WC102, and final reports shall be billed using procedure code WC103.
- (5) A medical provider shall not charge any fee for completing a medical report form required by the Division.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.16 ADDITIONAL REPORTS

Nothing in this rule shall preclude a carrier or an employee from requesting reports from a provider in addition to those specified in Rule 0800-2-17-.15.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.17 DEPOSITION/WITNESS FEE LIMITATION

- (1) Any provider who gives a deposition shall be allowed a witness fee.
- (2) Procedure Code 99075 must be used to bill for a deposition.
- (3) Licensed physicians shall be reimbursed for depositions at the same rate established in Rule 0800-2-16-.01

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.18 OUT-OF-STATE PROVIDERS

All services and requests for change-of-physician to out-of-state providers must be made to providers who agree to abide by the Division's Medical Fee Schedule Rules, In-patient Hospital Fee Schedule Rules and Medical Cost Containment Program Rules.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004).

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0800-2-17-.19 PREAUTHORIZATION

Preauthorization shall be required for all non-emergency hospitalizations, non-emergency transfers between facilities, and non-emergency outpatient services. Decisions regarding authorization must be communicated to the requesting provider within seven (7) business days. Failure to provide a timely decision within seven (7) business days shall result in the authorization being deemed approved. Any decision of denial for payment for any type of health care service and/or treatment resulting from a utilization review, as opposed to a determination of whether such service or treatment is related to a compensable injury or occupational disease, shall only be made by an agent of a Utilization Review Company properly approved by the Tennessee Department of Commerce and Insurance as prescribed in Rule 0800-2-6-.02. Upon emergency admission, notice must be given to the carrier within 24 hours or the next business day.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

0800-2-17-.20 PROCESS FOR RESOLVING DIFFERENCES BETWEEN CARRIERS AND PROVIDERS REGARDING BILLS

(1) Carrier's Dispute of a Bill

- (a) When a carrier adjusts and/or disputes a bill or portion thereof, the carrier shall notify the provider within thirty-one (31) calendar days of the receipt of the bill of the specific reasons for adjusting and/or disputing the bill or portion thereof, and shall notify the provider of its right to provide additional information and to request reconsideration of the carrier's action.
- (b) If the provider sends a bill to a carrier and the carrier does not respond in thirty-one (31) calendar days, and if a provider sends a second bill and receives no response within 62 days from the date the provider supplied the first bill, the provider may then proceed with whatever collection actions it deems appropriate in a court of law with proper jurisdiction.
- (c) The carrier shall notify the employer, employee and the provider that the rules prohibit a provider from billing an employee, employer, or carrier for any amount for health care services provided for the treatment of a compensable work-related injury, illness or occupational disease when that amount is disputed by the carrier pursuant to its utilization review program, or when the amount exceeds the maximum allowable payment established by the Fee Schedule Rules (Medical and In-patient Hospital). The carrier shall request the employee to notify the carrier if the provider so bills the employee, or employer.

(2) Provider's Request for Reconsideration of Bill

A provider may request reconsideration of its adjusted and/or disputed bill by a carrier within thirty-one (31) days of receipt of a notice of an adjusted and/or disputed bill or portion thereof. The provider's request to the carrier for reconsideration of the adjusted and/or disputed bill shall include a statement in detail of the reasons for disagreement with the carrier's adjustment and/or dispute of a bill or portion thereof.

(3) Carrier's Response to Provider's Request for Reconsideration of Bill; Provider's Right to Appeal

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- (a) Within thirty-one (31) calendar days of receipt of a provider's request for reconsideration, the carrier shall notify the provider of the actions taken and a detailed statement of the reasons. The carrier's notification shall include an explanation of the appeal process provided under this rule.
 - (b) If a provider is disagrees with the action taken by the carrier on its request for reconsideration, the provider may file a request for Administrative Review within thirty-one (31) calendar days from the date of receipt of a carrier's denial of the provider's request for reconsideration, and the provider shall supply a copy to the carrier.
 - (c) If within sixty-two (62) calendar days of the provider's request for reconsideration, the provider does not receive payment for the adjusted and/or disputed bill or portion thereof, or a written detailed statement of the reasons for the actions taken by the carrier, then the provider may make application for Administrative Review by the Medical MCCCC.
- (4) Disputes
- (a) Unresolved disputes between a carrier and provider concerning charges and/or due to conflicting interpretation of these Rules and/or the Medical Fee Schedule Rules and/or the In-patient Hospital Fee Schedule Rules may be presented to the Medical Care and Cost Containment Committee. A request for Administrative Review may be submitted to:

Medical Director of the Workers' Compensation Division,
Tennessee Department of Labor and Workforce Development
710 James Robertson Parkway, Andrew Johnson Tower, 2nd Floor
Nashville, Tennessee 37243.
 - (b) Valid requests for Administrative Review do not require a particular form but must be legible and contain copies of the following:
 - 1. Copies of the original and resubmitted bills in dispute which include dates of service, procedure codes, charges for services rendered and any payment received, and an explanation of unusual services or circumstances.
 - 2. Copies of the specific reimbursement.
 - 3. Supporting documentation and correspondence, if any.
 - 4. Specific information regarding contact with the carriers.
 - 5. A verified or declared written medical report signed by the physician.
 - 6. A specific written request for Administrative Review.
 - (c) The party requesting Administrative Review must send a copy of the request and all documentation accompanying the request to the opposing party as well.

Authority: T.C.A. §§ 50-6-126, 50-6-204, 50-6-205 (Supp. 2004), 50-6-226, 50-6-233 (Repl. 1999).

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0800-2-17-.21 ADMINISTRATIVE REVIEW OF FEE SCHEDULE DISPUTES/HEARINGS

(1) Administrative Review Procedure

- (a) When a request for Administrative Review by the MCCCC is received by the Division's Medical Director, the parties will be notified when the MCCCC will consider the dispute.
- (b) The MCCCC shall consider the dispute and issue its recommendation as to the proper resolution of the dispute.
- (c) If the parties to the dispute do not follow the recommendation of the MCCCC, then either party may proceed in any court of law with proper jurisdiction to decide the dispute.

(2) Computation of Time Periods

In computing a period of time prescribed or allowed by the Medical Fee Schedule Rules, Medical Cost Containment Program Rules and In-Patient Hospital Fee Schedule Rules, the day of the act, event or default from which the designated period of time begins to run shall not be included. The last day on which compliance therewith is required shall be included. If the last day within which an act shall be performed or an appeal filed is a Saturday, Sunday, or a legal holiday, the day shall be excluded, and the period shall run until the end of the next day which is not a Saturday, Sunday, or legal holiday. ["Legal holiday" means those days designated as a holiday by the President or Congress of the United States or so designated by the laws of this State.]

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.22 UTILIZATION REVIEW

(1) Scope of this part:

Requirements contained in this part shall pertain to utilization review activity as defined by T.C.A. § 50-6-124 (Repl. 1999) with respect to services by a provider for health care or health related services furnished as a result of a compensable injury, illness or occupational disease arising out of and in the course of employment. These Rules are intended to supplement and do not in any way displace the Division's Utilization Review Rules, Chapter 0800-2-6.

(2) Carrier's Utilization Review Program

- (a) The carrier shall have a utilization review program.
- (b) Utilization review shall be conducted in a reasonable manner and in accordance with this rule.
- (c) Under the utilization review program, the carrier shall do all of the following:
 - 1. Perform ongoing utilization review of medical bills to identify over-utilization of services and improper billing;

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2. Determine the accuracy of the procedure coding. If the carrier determines, based upon review of the bill and any related material which describes the procedure performed, that the procedure is incorrectly or incompletely coded, the carrier may recode the procedure, but shall notify the provider of the reasons for the recoding within 30 days of receipt of the bill;
 3. Reduce the bill to the maximum allowable payment for that procedure;
 4. Refer to the Division's Medical Director all providers whose billing practices indicate over-utilization.
 5. A carrier may have another certified entity perform utilization review activities on its behalf.
- (d) The utilization review program, whether operated by the carrier or an entity on behalf of the carrier, shall be certified by the Tennessee Department of Commerce and Insurance as prescribed in the Division's Rule 0800-2-6-.02.
- (e) The carrier shall provide the Division with the name, address, and license number (and a copy of the contract agreement between the carrier and other entity if applicable) of the entity responsible for conducting the carrier's utilization review program.
- (f) The carrier is responsible for notifying the Division when changing reviewing entities.
- (g) For purposes of this rule, a carrier which has another entity perform utilization review activities on its behalf maintains full responsibility for compliance with this rule.
- (h) Under the carrier's utilization review program, the carrier shall make determinations concerning a compensable injury, illness or occupational disease through one of the following approaches:
1. Review by licensed, registered, or certified health care professionals.
 2. The application of criteria developed by licensed, registered, or certified health care professionals.
 3. A combination of approaches in subdivisions (1) and (2) of this Subsection according to the type of covered injury or illness.
- (i) Licensed, registered, or certified health care professionals shall be involved in determining the carrier's response to a request by a provider for reconsideration of its bill.
- (j) These licensed, registered, or certified health care professionals shall have suitable occupational injury or disease expertise, or both, to render an informed clinical judgment on the medical appropriateness of the services provided.

Authority: T.C.A. § 50-6-124, 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

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0800-2-17-.23 RULE REVIEW

The Division encourages participation in the development of and changes to the Medical Cost Containment Program Rules, the Medical Fee Schedule Rules and the In-patient Hospital Fee Schedule Rules by all groups, associations, and the public. Any such group, association or other party desiring input into or changes made to these Rules and associated schedules must make their recommendations, in writing, to the Commissioner. After analysis, the Division may incorporate such recommended changes into Rules after appropriate consideration and public comment. The Medical Fee Schedule Rules, Medical Cost Containment Program Rules and In-Patient Hospital Fee Schedule Rules shall be reviewed by the Commissioner, in consultation with the Medical Care and Cost Containment Committee and the Advisory Council on Workers' Compensation July 2006 and on an annual basis thereafter. When appropriate, the Commissioner may revise the Fee Schedule Rules as necessary and appropriate.

Authority: T.C.A. § 50-6-204 (Supp. 2004).

0800-2-17-.24 PROVIDER AND FACILITY FEES FOR COPIES OF MEDICAL RECORDS

- (1) Health care providers and facilities are entitled to recover a reasonable amount to cover the cost of copying documents requested by the carrier, self-insured employer, employee, attorneys, etc. Documentation which is submitted by the provider and/or facility, but was not specifically requested by the carrier, shall not be allowed a copy charge.
- (2) Health care providers and facilities must furnish an injured employee or the employee's attorney and carriers/self-insureds or their legal representatives copies of records and reports upon request. The maximum charge allowed shall be the same as that set out in T.C.A. § 50-6-204, as amended.
- (3) Health care providers and facilities may charge the actual direct cost of copying x-rays, microfilm or other non-paper records.
- (4) The copying charge shall be paid by the party who requests the records.
- (5) An itemized invoice shall accompany the copy.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-17-.25 PENALTIES FOR VIOLATIONS OF FEE SCHEDULE RULES AND MEDICAL COST CONTAINMENT PROGRAM RULES

The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner, shall have the authority to assess civil penalties up to and including \$10,000.00 per violation, as set forth more fully in Rule 0800-2-17-.13, for violations of the Medical Fee Schedule Rules, In-patient Hospital Fee Schedule Rules or the Medical Cost Containment Program Rules.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

The notice of rulemaking set out herein was properly filed in the Department of State on the 20th day of July, 2005. (07-21)

RULEMAKING HEARINGS

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT - 0800 DIVISION OF WORKERS' COMPENSATION

There will be a hearing before the Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, to consider the promulgation of rules pursuant to Tenn. Code Ann. §§ 4-5-202, 4-5-204, 50-6-204, 50-6-205 and 50-6-233. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Hearing Room, 1st Floor, Andrew Johnson Tower, 710 James Robertson Parkway, Nashville, Tennessee 37243 at 9:00 a.m. CDST on the 23rd day of September, 2005.

Any individuals with disabilities who wish to participate in these proceedings (or to review these filings) should contact the Department of Labor and Workforce Development, Division of Workers' Compensation, to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings), to allow time for the Department to determine how it may reasonably provide such aid or service. Initial contact may be made with the Department's ADA Coordinator, Mr. Jewel Crawford, at Andrew Johnson Tower, 8th Floor, 710 James Robertson Parkway, Nashville, Tennessee 37243-0655 and (615) 741-8805.

For a copy of the entire text of this notice of rulemaking hearing contact: Vickie Gregory, Administrative Assistant, Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, Andrew Johnson Tower, Second Floor, 710 James Robertson Parkway, Nashville, TN 37243-0661, (615) 253-1613.

SUBSTANCE OF PROPOSED RULES

CHAPTER 0800-2-18 MEDICAL FEE SCHEDULE

NEW RULES

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0800-2-18-.03	General Guidelines	0800-2-18-.10	Durable Medical Equipment Guidelines
0800-2-18-.04	Surgery Guidelines	0800-2-18-.11	Orthotics, Prosthetics and Implants Guidelines
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0800-2-18-.06	Injections Guidelines	0800-2-18-.13	Ambulance Services Guidelines
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0800-2-18-.01 MEDICARE-BASIS FOR SYSTEM, APPLICABILITY, EFFECTIVE DATE AND CODING REFERENCES

- (1) The Medical Fee Schedule of the Tennessee Division of Workers' Compensation ("TDWC") is a Medicare-based system, but with multiple conversion factors. Only one geographical practice index is recognized in Tennessee under Medicare, therefore these Medical Fee Schedule rates apply state-wide. The Medical Fee Schedule is based upon the Centers for Medicare and Medicaid Services ("CMS") (formerly the Health Care Financing Administration's) ("HCFA") Medicare Resource Based Relative Value Scale ("RBRVS"), utilizing CMS' national relative value units and Tennessee specific conversion factors adopted by the Tennessee Division of Workers' Compensation. Anyone using this schedule must consult and be familiar with the Division's Medical Cost Containment Program rules, 0800-2-17-.01 et seq., the In-patient Hospital Fee Schedule rules, 0800-2-19.01 et seq., the most current American Medical Association ("AMA") CPT Codes, Health Care Financing Administration Common Procedure Coding System ("HCPCS"), American Society of Anesthesiologists ("ASA") Relative Value Guide, and the most current effective Medicare procedures and guidelines.
- (2) This Medical Fee Schedule must be used in conjunction with Medical Cost Containment Program Rules and the In-patient Hospital Fee Schedule Rules. The definitions set out in those rules, as well as the other general provisions, including but not limited to those regarding prompt payment of provider's bills, are adopted by reference as if set forth fully herein and those Rules must be used in conjunction with these Medical Fee Schedule Rules.
- (3) The Medical Fee Schedule Rules are effective July 1, 2005 and apply to all services provided on or after July 1, 2005. The most current versions of the American Medical Association's CPT and the Medicare RBRVS shall automatically be applicable and are adopted by these Rules by reference upon their effective dates. Fees shall be calculated using the edition of the CPT and RBRVS effective on the date of service.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.02.GENERAL INFORMATION AND INSTRUCTIONS FOR USE

- (1) Format

This schedule consists of the following sections: General Medicine (including Evaluation and Management), General Surgery, Neuro- and Orthopedic Surgery, Radiology, Pathology, Anesthesiology, Injections, Durable Medical Equipment, Implants and Orthotics, Pharmacy, Physical and Occupational Therapy, Ambulatory Surgical Centers and Outpatient Hospital Care, Chiropractic, Ambulance Services and Clinical Psychological Services. Providers should use the section(s) containing the procedure(s) they perform, or the service(s) they render.
- (2) Reimbursement
 - (a) Unless otherwise indicated herein, the most current Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and effective upon adoption and implementation by the CMS. Whenever there is no specific fee or methodology for reimbursement set forth in these Rules for a service, diagnostic procedure, equipment, etc., then the amount of reimbursement shall be at 100% of the most current effective CMS' Medicare allowable amount. The most current effective Medicare guidelines and procedures shall be followed in arriving at the correct amount. For purposes of these Rules,

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the Medicare amount may be adjusted upward annually based upon the annual Medicare Economic Index adjustment, but this amount shall never fall below the effective 2005 Medicare amount. Whenever there is no applicable Medicare code or method of reimbursement, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the lesser of the usual and customary amount, or the prevailing charge amount, and shall be billed By Report (“BR”).

(b) Reimbursement to all providers shall be the lesser of the following:

1. The provider’s usual charge;
2. The fee calculated according to the TDWC Fee Schedule Rules (includes 100% of Medicare if no other specific fee or methodology is set forth in these Rules);
3. The MCO/PPO or any other contracted price;
4. In no event shall reimbursement be in excess of these TDWC Fee Schedules, unless otherwise provided in the Division’s rules. Reimbursement in excess of the TDWC Medical Fee Schedule may result in civil penalties, at the Commissioner’s discretion, of \$10,000.00 per violation for each violation assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, should a pattern or practice of such activity be found. At the Commissioner’s discretion, such provider may also be reported to the appropriate certifying board or other appropriate authority, and may be subject to exclusion from participating further in providing care under the Tennessee Workers’ Compensation Act (“Act”).

(3) Fee Schedule Calculations

The TDWC Medical Fee Schedule amount can be calculated for any specific CPT code by multiplying the national “transitioned nonfacility total relative value units” (“RVUs”) by the conversion factor applicable to that CPT. Certain areas listed below do not have a conversion factor and the maximum reimbursement amount allowed is the usual and customary amount, as indicated. Other areas not listed below, such as dentistry, have a maximum reimbursement amount of 100% of the Medicare allowable amount calculated in accordance with then current effective Medicare guidelines and methodology.

(4) Conversion Factors—based on the CMS’ 2005 Tennessee unit amount of 37.8975

(a) The conversion factors applicable under this Medical Fee Schedule are:

	<u>Conversion Factor</u>	<u>As a percent of TN Medicare Rate</u>
Anesthesiology.....	Usual and Customary Amount	
Chiropractic Care.....	\$49.27	130%
General Surgery.....	\$75.80	200%
Home Health Care.....		100% of LUPA*
Home Infusion.....	Usual and Customary Amount	

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Gen. Medicine (includes unlisted specialties, Evaluation & Management, etc.)		
Office visits, E&M, etc. CPT codes	\$60.64	160%
Emergency care CPT codes	\$75.80	200%
Neurosurgery (board-eligible or certified physicians)	\$104.14	275%
(Non-board eligible physicians paid general surgery rate)		
Orthopedic Surg. (board-eligible or cert. physicians)	\$104.14	275%
(Non-board eligible physicians paid general surgery rate)		

Pathology..... Usual and Customary Amount

Physical and Occupational Therapy

Independently-owned Facilities-For First 6 visits	\$56.85	150%
Visits 7-12	\$49.27	130%
Visits over 12.....	\$37.90	100%
Physician-affiliated Facilities-For First 6 visits	\$49.27	130%
Visits 7-12.....	\$39.79	105%
Visits over 12.....	\$37.90	100%
Radiology	\$75.80	200%

- (b) The appropriate conversion factor should be determined by the type of CPT code for the procedure performed in all cases except those involving orthopedic and neurosurgery. The appropriate conversion factor for all surgical CPT codes for surgical procedures by any physician other than board-eligible neurosurgeons and orthopedic surgeons is \$75.80, (200% of Tennessee Medicare rates). Board-eligible and certified neurosurgeons and orthopedic surgeons shall use the neurosurgery and orthopedic surgery conversion factors only for surgery CPT codes. Evaluation and management CPT codes require the use of the associated conversion factor of \$60.64 (160% of Tennessee Medicare rates) by all physicians, including neurosurgeons and orthopedic surgeons.

*"LUPA" refers to the Medicare rates for Low Utilization Payment Adjustment.

(5) Forms

- (a) The following forms (or their official replacements) should be used for provider billing: HCFA 1500 and UB 92
- (b) Bills for reimbursement shall be sent directly to the party responsible for reimbursement. In most instances, this is the Insurance Carrier or the Self-Insured Employer. Insurance Carriers and/or Employers shall furnish this information to the Providers.

(6) Violations of Fee Schedules and Medical Cost Containment Rules

The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner, shall have the authority to issue civil penalties up to and including \$10,000.00 per violation for violations of the Medical Fee Schedule, In-patient Hospital Fee Schedule or the Medical Cost Containment Program Rules ("Rules") as prescribed in the Rules. Any party notified of an alleged violation, whether or not they are assessed civil penalties hereunder, shall be entitled to a contested case hearing before the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner pursuant to the Uniform Administrative Procedures Act, Tenn. Code Ann. § 4-5-101 et seq., if a written request is

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submitted to the Division by the party within fifteen (15) calendar days of issuance of notice of such violations and of any civil penalty. Failure to make a timely request will result in the violation and penalty decision becoming a final order and not subject to further review.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.03 GENERAL GUIDELINES

- (1) Guidelines define items that are necessary to appropriately interpret and report the procedures and services contained in a particular section and provide explanations regarding terms that apply only to a particular section.
- (2) The Guidelines found in the most current edition of the AMA's CPT apply to the following: General Medicine (includes Evaluation and Management), General Surgery, Neuro-surgery, Orthopedic Surgery, Chiropractic, Physical and Occupational Therapy, Home Health Care, Home Infusion, Ambulatory Surgical Centers and Outpatient Hospital Services, Radiology, Clinical Psychological, and Pathology. CDT-3 Codes of current dental terminology prescribed by the American Dental Association, including the terminology updates and revision issued in the future by the American Dental Association shall be used for all Dentistry services.
- (3) In addition to the Guidelines found in the AMA's CPT, the following Division's Guidelines also apply. Whenever a conflict exists between these Medical Fee Schedule Rules and any other fee schedule, rule or regulation, these Medical Fee Schedule Rules shall govern.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.04 SURGERY GUIDELINES

- (1) Multiple Procedures: Reimbursement shall be based on 100% of the physician's usual charge for the major procedure (not to exceed 100% of the TDWC Medical Fee Schedule amount allowable) plus 50% of the physician's usual charge for the lesser or secondary procedure (s) (not to exceed 50% of the TDWC Medical Fee Schedule allowable).
- (2) Services Rendered by More Than One Physician:
 - (a) Concurrent Care: One attending physician shall be in charge of the care of the injured employee. However, if the nature of the injury requires the concurrent services of two or more specialists for treatment, then each physician shall be entitled to the listed fee for services rendered.
 - (b) Surgical Assistant: A physician who assists at surgery may be reimbursed as a surgical assistant. To identify surgical assistant services provided by physicians, Modifier 80 or 81 shall be added to the surgical procedure code which is billed. A physician serving as a surgical assistant must submit a copy of the operative report to substantiate the services rendered. Reimbursement is limited to the lesser of the surgical assistant's usual charge or 20% of the maximum allowable Medical Fee Schedule amount. Duly licensed physician assistants may serve as surgical assistants as deemed appropriate by the physician, and if so, the licensed physician assistants' reimbursement shall not exceed the physician assistant fee due for the procedure as calculated pursuant to Medicare guidelines, not the conversion factors contained in the workers' compensation Medical Fee Schedule.

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- (c) Two Surgeons: For reporting see the most current CPT. Each surgeon must submit an operative report documenting the specific surgical procedure(s) provided. Each surgeon must submit an individual bill for the services rendered. Reimbursement must not be made to either surgeon until the carrier has received each surgeon's individual operative report and bill. Reimbursement to both surgeons shall not exceed 150% of the maximum allowable Fee Schedule amount of the first surgeon and shall be allocated between the surgeons as agreed by them.
- (3) When a surgical fee is chargeable, no office visit charge shall be allowed for the day on which this surgical fee is earned, except if surgery is performed on the same day as the physician's first examination. All exceptions require use of the appropriate modifiers and shall be filed BR.
- (4) Certain of the listed procedures in the Medical Fee Schedule are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge.
- (5) Lacerations ordinarily require no aftercare except removal of sutures. The removal is considered a routine part of an office or hospital visit and shall not be billed separately unless such sutures are removed by a provider different from the provider administering the sutures.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.05 ANESTHESIA GUIDELINES

- (1) General Information and Instructions.
 - (a) The current ASA Relative Value Guide, by the American Society of Anesthesiologists will be used to determine reimbursement for anesthesia codes that do not appear in the RBRVS. These values are to be used only when the anesthesia is personally administered by an Anesthesiologist or Certified Registered Nurse Anesthetist ("CRNA") who remains in constant attendance during the procedure, for the sole purpose of rendering such anesthesia service. To order the Relative Value Guide, write to the American Society of Anesthesiologists, 520 N Northwest Highway; Park Ridge, IL 60068-2573, or call (847) 825-5586.
 - (b) When anesthesia is administered by a CRNA not under the medical direction of an anesthesiologist, reimbursement shall be 90% of the provider's usual and customary charge. No payment will be made to the surgeon supervising the CRNA.
 - (c) When anesthesia is administered personally by an anesthesiologist or administered by a care team involving an anesthesiologist and CRNA, reimbursement shall not exceed 100% of the provider's usual and customary charge.
- (2) Anesthesia Values
 - (a) Each anesthesia service contains two value components which make up the charge and determine reimbursement: a Basic Value and a Time Value.
 - (b) Basic Value: This relates to the complexity of the service and includes the value of all usual anesthesia services except the time actually spent in anesthesia care and any modifiers. The Basic Value includes usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood

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products incidental to the anesthesia or surgery and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). When multiple surgical procedures are performed during an operative session, the Basic Value for anesthesia is the Basic Value for the procedure with the highest unit value. The Basic Values in units for each anesthesia procedure code are listed in the current ASA Relative Value Guide.

- (c) Time Value: Anesthesia time starts when the anesthesiologist or CRNA begins to prepare the patient for induction of anesthesia and ends when the personal attendance of the anesthesiologist or CRNA is no longer required and the patient can be safely placed under customary, postoperative supervision. Anesthesia time must be reported on the claim form as the total number of minutes of anesthesia. For example, one hour and eleven minutes equals 71 minutes of anesthesia. The Time Value is converted into units for reimbursement as follows:

1. Each 15 minutes or any fraction thereof equals one (1) time unit. For example, 71 minutes of anesthesia time would have the following time units: $71/15 = 5$ Time Units.
2. No additional time units are allowed for recovery room observation monitoring after the patient can be safely placed under customary post-operative supervision.

(3) Total Anesthesia Value

The total anesthesia value ("TAV") for an anesthesia service is the sum of the Basic Value (units) plus the Time Value which has been converted into units. The TAV is calculated for the purpose of determining reimbursement.

(4) Billing

Anesthesia services must be reported by entering the appropriate anesthesia procedure code and descriptor into Element 24 D of the HCFA 1500 Form. The provider's usual total charge for the anesthesia service must be entered in Element 24 F on the HCFA 1500 Form. The total time in minutes must be entered in Element 24 G of the HCFA 1500 Form.

(5) Reimbursement

Reimbursement for anesthesia services must be no more than the provider's usual and customary charge.

(6) Medical Direction Provided by Anesthesiologists

When an anesthesiologist is not personally administering the anesthesia but is providing medical direction for the services of a nurse anesthetist who is not employed by the anesthesiologist, the anesthesiologist may bill for the medical direction. Medical direction includes the pre and post-operative evaluation of the patient. The anesthesiologist must remain within the operating suite, including the pre-anesthesia and post-anesthesia recovery areas, except in extreme emergency situations. Reimbursement shall not exceed 100% of the provider's usual and customary charge.

(7) Anesthesia by Surgeon

- (a) Local Anesthesia

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When infiltration, digital block or topical anesthesia is administered by the operating surgeon or surgeon's assistant, reimbursement for the procedure and anesthesia are included in the global reimbursement for the procedure.

(b) Regional or General Anesthesia

1. When regional or general anesthesia is provided by the operating surgeon or surgeon's assistant, the surgeon may be reimbursed for the anesthesia service in addition to the surgical procedure.
 - (i) To identify the anesthesia service, list the CPT surgical procedure code and add Modifier 47.
 - (ii) Reimbursement shall not exceed the provider's usual and customary charge.
 - (iii) The operating surgeon must not use the diagnostic or therapeutic nerve block codes to bill for administering regional anesthesia for a surgical procedure.
- (8) Unlisted Service, Procedure or Unit Value. When an unlisted service or procedure is provided or without specified unit values, the values used shall be substantiated BR.
- (9) Procedures Listed In The ASA Relative Value Guide Without Specified Unit Values. For any procedure or service that is unlisted or without specified unit value, the physician or anesthesiologist shall establish a unit value consistent in relativity with other unit values shown in the current ASA Relative Value Guide. Pertinent information concerning the nature, extent and need for the procedure or service, the time, the skill and equipment necessary, etc., shall be furnished. Sufficient information shall be furnished to identify the problem and the service(s).
- (10) Actual time of beginning and duration of anesthesia time may require documentation, such as a copy of the anesthesia record in the hospital file.
- (11) Special Supplies. Supplies and materials provided by the physician over and above those usually included with the office visit or other services rendered may be listed separately. Drugs, materials provided, and tray supplies shall be listed separately. Supplies and materials provided in a hospital or other facility must not be billed separately by the physician or CRNA. These charges must be billed by the hospital.
- (12) Separate or Multiple Procedures. It is appropriate to designate multiple procedures that are rendered on the same date by separate entries.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.06 INJECTIONS GUIDELINES

Reimbursement for injection(s) (such as J codes) includes allowance for CPT code 90782 in addition to average wholesale price of each drug. In cases where multiple drugs are given as one injection, only one administration fee is owed. Surgery procedure codes defined as injections include the administration portion of payment for the medications billed. J Codes are found in the Health Care Financing Administration Common Procedure Coding System ("HCPCS").

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

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0800-2-18-.07 AMBULATORY SURGICAL CENTERS AND OUTPATIENT HOSPITAL CARE (INCLUDING EMERGENCY ROOM FACILITY CHARGES)

When medically appropriate, surgical procedures may be performed on an outpatient basis to reduce unnecessary hospitalization and to shift care to a less costly setting.

- (1) For the purpose of the TDWC Medical Fee Schedule, “ambulatory surgical center” means an establishment with an organized medical staff of physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous physicians and registered nurses on site or on call; which provides services and accommodations for patients to recover for a period not to exceed twenty-three (23) hours after surgery. An ambulatory surgical center may be a free standing facility or may be attached to a hospital facility. For purposes of workers’ compensation reimbursement to ASCs, the facility must be an approved Medicare ASC.
- (2) The CMS has implemented a prospective payment system (“PPS”) under Medicare for hospital outpatient services. All services paid under the new PPS are classified into groups called Ambulatory Payment Classifications (“APC”). Services in each APC are similar clinically and in terms of the resources they require. The CMS has established a payment rate for each APC.
- (3) The most current Medicare APC rates shall be used as the basis for facility fees charged for services provided in an ambulatory surgical center (“ASC”) and shall be reimbursed at a maximum of 150% of current value for such services at ASCs. Depending on the services provided, ASCs may be paid for more than one APC for an encounter. When multiple procedures are performed during the same surgical session, the reimbursement shall be made at 100% of the appropriate rate for the highest charge procedure and 50% of the appropriate rate for all additional procedures. Only separate and distinct surgical procedures shall be billed. When applicable, the Medicare Guidelines shall be used in determining separate and distinct surgical procedures.
- (4) All other outpatient hospital care, including but not limited to observation and emergency room facility fees, shall be calculated in accordance with the most current Medicare rules and procedures applicable to such service and shall be reimbursed at a maximum rate of 150% of the current value of Medicare reimbursement for outpatient hospital care.
- (5) Facility services do not include (the following services may be billed separately from the facility fees):
 - (a) Physician services
 - (b) Laboratory services
 - (c) X-rays
 - (d) Diagnostic procedures not related to the surgical procedure
 - (e) Prosthetic devices
 - (f) Ambulance services
 - (g) Orthotics
 - (h) Implantables
 - (i) DME for use in the patient’s home

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- (j) CRNA or Anesthesia Physician Services (supervision of CRNA is included in the facility)
- (k) Take home medications
- (l) Take home supplies
- (6) The above list of services and supplies shall be reimbursed according to the TDWC Fee Schedule Rules or at the usual and customary charge (for items not listed in the fee schedule rules).
- (7) There may be occasions in which the patient was scheduled for out patient surgery and it becomes necessary to admit the patient. All ambulatory patients who are admitted to the hospital and stay longer than 23 hours past ambulatory surgery will be paid according to the Inpatient Hospital Fee Schedule Rules, 0800-2-19.01 et seq.
- (8) Pre-admission lab and x-ray may be billed separately from the Ambulatory Surgery bill when performed 24 hours or more prior to admission, and will be reimbursed the lesser of billed charges or the payment limit of the fee schedule. Pre-admission lab and radiology are not included in the facility fee.
- (9) Facility fees for surgical procedures not listed shall be reimbursed BR at the usual and customary rate.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.08 CHIROPRACTIC SERVICES GUIDELINES

- (1) Charges for chiropractic services shall not exceed 130% of the participating fees prescribed in the Medicare RBRVS System fee schedule. The number of approved visits shall be limited pursuant to any restrictions in T.C.A. § 50-6-204. The same procedures for certification applicable to physical therapy and occupational therapy services under Rule 0800-2-18-.09(5) below apply to chiropractic services (such as UR review after 12 visits), except that the thirty (30) day time period therein shall not apply to chiropractic services.
- (2) For chiropractic services, an office visit shall not be billed on the same day as a manipulation is billed.
- (3) If allowable payment for chiropractic services is not paid by employers or insurers for chiropractic services provided to employees who have suffered a compensable work-related injury under the Workers' Compensation Law within thirty-one (31) days from the date of receipt by the employer or insurer of the bill for chiropractic services provided to such an employee, interest at the rate of 25% per annum of the payment allowed pursuant to these rules, compounded monthly, may be charged and paid as set forth in Rule 0800-2-11-.10 of the Medical Cost Containment Program Rules.
- (4) There shall be no fee allowable for any modalities performed in excess of four (4) modalities per day per employee. The Medicare definition of modality is applicable.
- (5) There shall be no charge for either hot packs or cold packs provided to an employee who has suffered a compensable work-related injury under the Workers' Compensation Law.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

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0800-2-18-.09 PHYSICAL AND OCCUPATIONAL THERAPY GUIDELINES

- (1) Charges for physical and/or occupational therapy services shall be reimbursed on a bifurcated sliding scale based upon physician interest in the facility providing services. For the purpose of this Medical Fee Schedule, a “physician-affiliated” facility is one in which the referring physician has any type of financial interest, which includes, but is not limited to, any type of ownership, interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect benefit of any kind, whether in money or otherwise, between the facility to whom the physician refers a person for services and that physician. Any hospital-based PT or OT facility shall also be deemed “physician-affiliated” if the referring physician is an employee of such hospital, or if he or she receives a benefit of any kind from the referral.
 - (a) Independently-owned and operated facilities’ reimbursement shall not exceed one hundred fifty percent (150%) of the participating fees prescribed in the Medicare RBRVS System fee schedule (Medicare Fee Schedule) for the first six (6) visits, and shall not exceed one hundred thirty percent (130%) for visits 7 through 12. For all visits after visit 12, reimbursement shall not exceed one hundred percent (100%).
 - (b) Physician-affiliated facilities’ reimbursement shall not exceed one hundred thirty percent (130%) of the participating fees prescribed in the Medicare RBRVS System fee schedule for the first six (6) visits, and shall not exceed one hundred five percent (105%) for visits 7 through 12. For all visits after visit 12, reimbursement shall not exceed one hundred percent (100%).
- (2) For physical therapy and/or occupational therapy, there shall be no charge for either hot packs or cold packs provided to an employee who has suffered a compensable work-related injury under the Workers’ Compensation Law.
- (3) For physical therapy and/or occupational therapy, there shall be no fee allowable for any modalities performed in excess of four (4) modalities per day per employee. The Medicare definition of modality is applicable.
- (4) Any procedure for which an appropriate Medicare code is not available, such as a Functional Capacity Evaluation or work hardening, shall be billed BR. The lesser of the prevailing charge or the usual and customary charge shall be the maximum amount reimbursable for such services.
- (5) Whenever physical therapy and/or occupational therapy services exceed twelve (12) sessions/visits or a period over thirty (30) days, whichever comes first, then such treatment shall be reviewed pursuant to the carrier’s utilization review program in accordance with the procedures set forth in 0800-2-6 of the Division’s Utilization Review rules before further physical therapy and/or occupational therapy services may be certified for payment by the carrier. Such certification shall be completed within two (2) business days of any request for certification to assure no interruption in delivery of needed services. Failure to properly certify such services as prescribed herein shall result in the forfeiture of any payment for uncertified services. The initial utilization review of physical therapy and/or occupational therapy services shall, if necessary and appropriate, certify an appropriate number of sessions/visits. If necessary, further subsequent utilization review shall be conducted to certify additional physical therapy and/or occupational therapy services as is appropriate.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

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0800-2-18-.10 DURABLE MEDICAL EQUIPMENT GUIDELINES

All durable medical equipment shall be reimbursed at a maximum of the invoice amount plus the lesser of 15% of invoice or \$1,000.00, and coded using the HCPCS codes. Charges for durable medical equipment are in addition to, and shall be billed separately from, all facility and professional service fees. Supplies and equipment not addressed in this fee guideline shall be reimbursed at a reasonable amount, as defined in these Rules and coded 99070 if appropriate codes are not available in the HCPCS. All billing must contain the brand name, model number, and catalog number. Codes to be used are found in the HCPCS. Charges should be submitted on a HCFA 1500 form.

- (1) Quality. The reimbursement for supplies/equipment in this fee guideline is based on a presumption that the injured worker is being provided the highest quality of supplies/equipment. All billing must contain the brand name, model number, and catalog number.
- (2) Rental/Purchase. Rental fees are applicable in instances of short-term utilization (30-60 days). If it is more cost effective to purchase an item rather than rent it, this must be stressed and brought to the attention of the insurance carrier. The first month's rent should apply to the purchase price. However, if the decision to purchase an item is delayed by the insurance carrier, subsequent rental fees cannot be applied to the purchase price. When billing for rental, identify with modifier "RR".
- (3) TENs Units. All bills submitted to the carrier for Tens and Cranial Electrical Stimulator (CES) units should be accompanied by a copy of the invoice, if available.
 - (a) Rentals
 1. Include the following supplies:
 - (i) lead wires;
 - (ii) two (2) rechargeable batteries;
 - (iii) battery charger;
 - (iv) electrodes; and
 - (v) instruction manual and/or audio tape.
 2. Supplies submitted for reimbursement must be itemized. In unusual circumstances where additional supplies are necessary, use modifier 22 and "BR"
 3. Limited to 30 days trial period.
 - (b) Purchase:
 1. Prior to the completion of the 30-day trial period, the prescribing doctor must submit a report documenting the medical justification for the continued use of the unit. The report should identify the following:
 - (i) Describe the condition and diagnosis that necessitates the use of a TENs unit.
 - (ii) Does the patient have any other implants which would affect the performance of the TENs unit or the implanted unit?

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- (iii) Was the TENs unit effective for pain control during the trial period?
 - (iv) Was the patient instructed on the proper use of the TENS unit during the trial period?
 - (v) How often does the patient use the TENS unit?
 - 2. The purchase price should include the items below if not already included with the rental:
 - (i) lead wires;
 - (ii) two (2) rechargeable batteries; and
 - (iii) a battery charger.
 - 3. Only the first month's rental price shall be credited to purchase price.
 - 4. Provider shall indicate TENs manufacturer, model name, and serial number.
- (4) Continuous and Passive Motion (Use Code D0540)
- Use of this unit in excess of 30 days requires documentation of medical necessity by the doctor. Only one (1) set of soft goods will be allowed for purchase.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.11 ORTHOTICS, PROSTHETICS AND IMPLANTS GUIDELINES

Implants, orthotics and prosthetics should be coded according to the HCFA Common Procedures Coding System (HCPCS). Copies may be obtained from the American Orthotic and Prosthetic Association, 1650 King Street, Suite 500, Alexandria, VA 22314, (703) 836-7116. Implants, orthotics and prosthetics shall be reimbursed at the supplier's invoice amount, plus 15% of the invoice amount or \$1,000.00, whichever is less, and coded using the HCPCS code. Charges for these items are in addition to, and shall be billed separately from, all facility and professional service fees. Supplies and equipment should be coded 99070 if appropriate codes are not available in the HCPCS. All billing must contain the brand name, model number, and catalog number. Charges should be submitted on a HCFA 1500 form.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.12 PHARMACY SCHEDULE GUIDELINES

The Pharmaceutical Fee Guideline Amount for prescribed drugs (medicines by pharmacists and dispensing practitioners) under the Tennessee workers' compensation laws is the lesser of:

- (1) The provider's usual charge;
- (2) A negotiated contract amount; or
- (3) The fees established by the formula for brand-name and generic pharmaceuticals as described in subsection (5) of this section.

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(4) Prescribed Medication Services

- (a) "Drug" has the meaning set out in T. C. A. § 63-10-204.
- (b) Medicine or drugs may only be dispensed by a currently licensed pharmacist or a dispensing practitioner.
- (c) Carriers may contract with pharmacy benefit managers to process and administer claims for reimbursement of pharmacy services and review the relatedness and appropriateness of prescribed services. Carriers and pharmacists may also negotiate alternative reimbursement schedules and amounts, so long as the reimbursement amount does not exceed the fee schedule amount set out in these Rules.
- (d) For the purposes of these TWCD Medical Fee Schedule Rules, medicines are defined as drugs prescribed by an authorized health care provider and include only generic drugs or single-source patented drugs for which there is no generic equivalent, unless the authorized health care provider writes that the brand name is medically necessary and includes on the prescription "dispense as written."

(5) Reimbursement

- (a) The pharmaceutical reimbursement formula for prescribed drugs (medicines by pharmacists and dispensing practitioners) is the lesser of:

Average Wholesale Price* ("AWP") + \$5.10 filling fee, the provider's usual charge, or a negotiated contractual amount.

* The Commissioner may at any time adopt and implement a different base price other than AWP (such as average sales price), should medical reimbursement standards and/or local or other practices warrant, at the Commissioner's discretion.

- (b) Reimbursement to pharmacists must not exceed the amount calculated by the pharmaceutical reimbursement formula for prescribed drugs. A generic drug must be substituted for any brand name drug unless: 1) there is no pharmaceutical and bioequivalent drug available, or 2) the prescribing physician indicates that substitutions are prohibited by including the words "Dispense as Written", or "No Substitution Allowed" in the prescriber's own handwriting, along with a statement that the brand name drug is medically necessary. A prescribing physician may also prohibit substitution of generic drugs by oral or electronic communication to the pharmacist so long as the same content is conveyed that is required in a written prescription. A lower cost, therapeutically equivalent drug may be substituted for a prescribed drug if the requirements set out in Title 63, Chapter 10, Part 2 of Tennessee Code Annotated are all met.

- 1. A bill or receipt for a prescription drug shall include all of the following:
 - (i) When a brand name drug with a generic equivalent is dispensed, the brand name and the generic name shall be included unless the prescriber indicates "do not label."
 - (ii) If the drug has no brand name, the generic name, and the manufacturer's name or the supplier's name, shall be included, unless the prescriber indicates "do not label."
 - (iii) The strength, unless the prescriber indicates "do not label."
 - (iv) The quantity dispensed.

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- (v) The dosage.
 - (vi) The name, address, and federal tax ID# of the pharmacy.
 - (vii) The prescription number, if available.
 - (viii) The date dispensed.
 - (ix) The name of the prescriber.
 - (x) The name of the patient.
 - (xi) The price for which the drug was sold to the purchaser.
 - (xii) The National Drug Code Number ("NDC Number").
2. The AWP shall be determined from the appropriate monthly publication. The monthly publication that shall be used for calculation shall be the same as the date of service. When an AWP is changed during the month, the provider shall still use the AWP from the monthly publication. The publications to be used are:
- (i) Primary reference. Price Alert from First Data Bank.
 - (ii) Secondary reference (for drugs NOT found in PriceAlert). Red Book from Medical Economics.
3. Dietary supplements such as minerals and vitamins shall not be reimbursable unless a specific compensable dietary deficiency has been clinically established in the injured employee as a result of the work-related injury.
4. A compounding fee not to exceed Twenty-five Dollars (\$25.00) per compound prescription may be charged if two (2) or more prescriptive drugs require compound preparation when sold by a hospital, pharmacy, or provider of service other than a physician.
5. If allowable payment for prescriptive drugs is not paid by employers or carriers for prescriptions provided to employees who have suffered a compensable work-related injury under the Workers' Compensation Law within thirty-one (31) days from the date of receipt by the employer or insurer of the bill for prescriptive drugs provided to such an employee, interest at the rate of 2.08% /month of the payment allowed pursuant to these rules may be charged by a hospital, pharmacy, or provider of such service as set forth in Rule 0800-2-11-.10 of the Medical Cost Containment Program Rules.
6. If a workers' compensation claimant chooses a brand-name medicine when a generic medicine is available and allowed by the prescriber, the claimant shall pay the difference in price between the brand-name and generic medicine and shall not be eligible to subsequently recover this difference in cost from the employer or carrier.
- (6) "Patent" or 'Proprietary Preparations"
- (a) "Patent" or "Proprietary preparations," frequently called "over-the-counter drugs," are sometimes prescribed for a work-related injury or illness instead of a legend drug.

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- (b) Generic substitution as discussed in (4)(b) above applies also to “over-the-counter” preparations.
 - (c) Pharmacists must bill and be reimbursed their usual and customary charge for the “over-the-counter” drug(s).
 - (d) The reimbursement formula does not apply to the “over-the-counter” drugs and no filling fee may be reimbursed.
- (7) Dispensing Practitioner
- (a) Dispensing practitioners shall be reimbursed the same as pharmacists for prescribed drugs (medicines), except such practitioners shall not receive a filling fee.
 - (b) “Patent” or “proprietary preparations” frequently called “over-the-counter drugs,” dispensed by a physician(s) from their office(s) to a patient during an office visit should be billed as follows:
 - 1. Procedure Code 99070 must be used to bill for the “proprietary preparation” and the name of the preparation, dosage and package size must be listed as the descriptor.
 - 2. An invoice indicating the cost of the “proprietary preparation” must be submitted to the carrier with the HCFA 1500 Form.
 - 3. Reimbursement is limited to the lesser of the provider’s charge or 20 percent above the actual cost of the item.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.13 AMBULANCE SERVICES GUIDELINES

- (1) All non-emergency ground and air ambulance service provided to workers’ compensation claimants shall be pre-certified. Emergency ground and air ambulance services shall be retro-certified within 24 hours of the service or on the next business day.
- (2) All ground and air ambulance services shall be medically necessary and appropriate. Documentation, trip sheets, shall be submitted with the bill that states the condition that indicates the necessity of the ground and air ambulance service provided. It should readily indicate the need for transport via this mode rather than another less expensive form of transportation. The service billed shall be supported by the documentation submitted for review.
- (3) Billing shall be submitted to the employer or carrier on a properly completed HCFA 1500 claim form by HCPCS code. Hospital based or owned providers must submit charges on a HCFA 1500 form by HCPCS code.
- (4) Reimbursement shall be:

Based upon the lesser of the submitted charge or the prevailing reimbursement rate for ambulances within the geographic locality. These charges shall not exceed the prevailing charges in that locality for comparable services under comparable circumstances and commensurate with the services actually performed. Ambulance services shall be paid on a two (2) part basis, the first level being the level of care, the second being a mileage allowance. The services rendered are independent of the type of call received.

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Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.14 CLINICAL PSYCHOLOGICAL SERVICE GUIDELINES

- (1) Reimbursement for psychological treatment services by any clinician other than a licensed psychiatrist shall be based on reasonableness and necessity and shall be reimbursed at 100% of the participating fees prescribed in the Medicare RBRVS System fee schedule (Medicare Fee Schedule). Treatment by a licensed psychiatrist shall be reimbursed as any other evaluation and management medical treatment under this Medical Fee Schedule.
- (2) Whenever such psychological treatment services exceed fifteen (15) sessions/visits, then such treatment shall be reviewed pursuant to the carrier's utilization review program in accordance with the procedures set forth in 0800-2-6 of the Division's Utilization Review rules before further psychological treatment services may be certified for payment by the carrier. Failure to properly certify such services as prescribed herein shall result in the forfeiture of any payment for uncertified services. The initial utilization review of psychological treatment services after the first fifteen (15) sessions/visits shall, if necessary and appropriate, certify an appropriate number of sessions/visits. If necessary, further subsequent utilization review shall be conducted to certify additional psychological treatment services as is appropriate.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

0800-2-18-.15 PENALTIES FOR VIOLATIONS OF FEE SCHEDULES

- (1) Providers shall not accept and employers or carriers shall not pay any amount for health care services provided for the treatment of a covered injury or illness or for any other services encompassed within the Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules. Any provider accepting and any employer or carrier paying an amount in excess of the TDWC Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules shall be in violation of these Rules and may, at the Commissioner's discretion, be subject to civil penalties of ten thousand dollars (\$10,000.00) per violation for each violation, which may be assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee whenever a pattern or practice of such activity is found. At the discretion of the Commissioner, the Commissioner's Designee, or an agency member appointed by the Commissioner, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act. Any other violation of the Medical Cost Containment Program Rules, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules shall subject the violator(s) to a civil penalty of not less than one hundred dollars (\$100.00) nor more than ten thousand dollars (\$10,000.00) per violation, at the discretion of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner.
- (2) A provider, employer or carrier found to be in violation of these Rules, whether a civil penalty is assessed or not, may request a contested case hearing by requesting such hearing in writing within fifteen (15) calendar days of issuance of a Notice of Violation and, if applicable, notice of assessment of civil penalties.
- (3) The request for a hearing shall be made to the Division in writing by an employer, carrier or provider which has been notified of its violation of these Rules, and if applicable, assessed a civil penalty.

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- (4) Any request for a hearing shall be filed with the Division within fifteen (15) calendar days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty by the Commissioner. Failure to file a request for a hearing within fifteen (15) calendar days of the date of issuance of a Notice of Violation shall result in the decision of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner being deemed a final order and not subject to further review.
- (5) The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner shall have the authority to hear any matter as a contested case and determine if any civil penalty assessed should have been assessed.
- (6) Upon receipt of a timely filed request for a hearing, the Commissioner shall issue a Notice of Hearing to all interested parties.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999)

The notice of rulemaking set out herein was properly filed in the Department of State on the 20th day of July, 2005. (07-22)

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TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT - 0800 DIVISION OF WORKERS' COMPENSATION

There will be a hearing before the Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, to consider the promulgation of rules pursuant to Tenn. Code Ann. §§ 4-5-202, 4-5-204, 50-6-204, 50-6-205 and 50-6-233. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Hearing Room, 1st Floor, Andrew Johnson Tower, 710 James Robertson Parkway, Nashville, Tennessee 37243 at 9:00 a.m. CDST on the 23rd day of September, 2005.

Any individuals with disabilities who wish to participate in these proceedings (or to review these filings) should contact the Department of Labor and Workforce Development, Division of Workers' Compensation, to discuss any auxiliary aids or services needed to facilitate such participation. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date the party intends to review such filings), to allow time for the Department to determine how it may reasonably provide such aid or service. Initial contact may be made with the Department's ADA Coordinator, Mr. Jewel Crawford, at Andrew Johnson Tower, 8th Floor, 710 James Robertson Parkway, Nashville, Tennessee 37243-0655 and (615) 741-8805.

For a copy of the entire text of this notice of rulemaking hearing contact: Vickie Gregory, Administrative Assistant, Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, Andrew Johnson Tower, Second Floor, 710 James Robertson Parkway, Nashville, TN 37243-0661, (615) 253-1613.

SUBSTANCE OF PROPOSED RULES

CHAPTER 0800-2-19

IN-PATIENT HOSPITAL FEE SCHEDULE

NEW RULES

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0800-2-19-.01	General Rules
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0800-2-19-.01 GENERAL RULES

- (1) This In-patient Hospital Fee Schedule shall be effective July 1, 2005 and is applicable for all inpatient services as defined herein, and includes medical, surgical, rehabilitation, and/or psychiatric services rendered in a hospital to injured workers under the Tennessee Workers' Compensation Act. Maximum fees for outpatient hospital services are not addressed in this In-patient Hospital Fee Schedule, but are contained in the Medical Fee Schedule Rules, 0800-2-18-.01 et seq. This In-patient Hospital Fee Schedule is established pursuant to Tenn. Code Ann. § 50-6-204 (Supp. 2004) is effective July 1, 2005, and must be used in conjunction with the Medical Cost Containment Program Rules, 0800-2-17-.01 et seq. and the Medical

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Fee Schedule Rules, 0800-2-18-.01 et seq. as the definitions and general provisions set forth in those rules are incorporated as if set forth fully herein.

(2) General Information

- (a) Reimbursements shall be determined for services rendered in accordance with this fee schedule and shall be considered to be inclusive unless otherwise noted.
- (b) The most current Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and shall be effective upon adoption and implementation by the CMS. Whenever there is no specific fee or methodology for reimbursement set forth in these Rules for a service, diagnostic procedure, equipment, etc., then the amount of reimbursement shall be at 100% of the 2005 CMS' Medicare amount and the most current effective Medicare guidelines and procedures shall be followed in arriving at the correct amount. The Medicare amount may, at the Commissioner's discretion, be adjusted upward annually based upon CMS' annual Medicare Economic Index adjustment, but this amount shall never fall below the effective 2005 Medicare amount. Whenever there is no applicable Medicare code, the service, equipment, diagnostic procedure, etc. shall be reimbursed at the lesser of the usual and customary or the prevailing charge amount and be billed By Report.
- (c) Reimbursement for a compensable workers' compensation claim shall be the lesser of the hospital's usual and customary charges, the prevailing charge amount, or the maximum amount allowed under this Inpatient Hospital Fee Schedule.
- (d) Inpatient hospitals shall be grouped into the following separate peer groupings:

Peer Group	1	Hospitals
Peer Group	2	Rehabilitation Hospitals
Peer Group	3	Psychiatric Hospitals
- (e) For each inpatient claim submitted, the provider shall assign a Medicare Diagnosis Related Group ("DRG") code which appropriately reflects the patient's primary cause of hospitalization.
- (f) The inpatient hospital fee schedule shall become effective July 1, 2005 and shall be reviewed annually and may be updated annually.
- (g) Ongoing analysis will be conducted as to the projected savings of this schedule, as well as any impact on patient services.
- (h) Preauthorization is required for specific inpatient services.

Authority: T.C.A. §§ 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

0800-2-19-.02 DEFINITIONS

- (1) "Administrator" means the chief administrative officer of the Division of Workers' Compensation of the Tennessee Department of Labor and Workforce Development.

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- (2) "Allowed Charges" or "Allowable Charges" shall mean charges reviewed and approved under an appropriate audit and utilization review by the carrier as prescribed in the Division's Rules, or as determined by the Commissioner or the Commissioner's designee after consultation with the Division's Medical Director.
- (3) "Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development.
- (4) "Division" means the Division of Workers' Compensation of the Tennessee Department of Labor and Workforce Development.
- (5) DRG – Medicare classifications of diagnosis in which patients demonstrate similar resource consumption and length of stay patterns.
- (6) In-patient Services - Services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds 23 hours.
- (7) Institutional Services - All non-physician services rendered within the institution by an agent of the institution.
- (8) Length of Stay ("LOS") - Number of days of admission where patient appears on midnight census. Last day of stay shall count as an admission day if it is medically necessary for the patient to remain in the hospital beyond 12:00 noon.
- (9) Medical Admission - Any hospital admission where the primary services rendered are not surgical, psychiatric, or rehabilitative in nature.
- (10) Stop-Loss Payment ("SLP") - An independent method of payment for an unusually costly or lengthy stay.
- (11) Stop-Loss Reimbursement Factor ("SLRF") - A factor established by the Division to be used as a multiplier to establish a reimbursement amount when total hospital charges have exceeded specific stop-loss thresholds.
- (12) Stop-Loss Threshold ("SLT") - Threshold of total charges established by the Division, beyond which reimbursement is calculated by multiplying the applicable Stop-Loss Reimbursement Factor times the total charges identifying that particular threshold.
- (13) Surgical Admission - Any hospital admission where there is an operating room charge, the patient has a surgical procedure code, or the patient has a surgical DRG as defined by the CMS.
- (14) Transfers Between Facilities - To move or remove a patient from one facility to another for a purpose related to obtaining or continuing medical care. May or may not involve a change in the admittance status of the patient, i.e. patient transported from one facility to another to obtain specific care, diagnostic testing, or other medical services not available in facility in which patient has been admitted. Includes costs related to transportation of patient to obtain medical care.
- (15) "Trauma Admission" - means any hospital admission in which the patient has a diagnosis code of 800 to 959.99.

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- (16) "Usual and customary charge" means a particular provider's average charge for a procedure to all payment sources, and includes itemized charges previously billed separately which are included in the package for that procedure as defined by this rule.
- (17) Workers' Compensation Standard Per Diem Amount ("SPDA") - A standardized per diem amount established for the reimbursement of hospitals for services rendered.

Authority: T.C.A. §§ 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

0800-2-19-.03 SPECIAL GROUND RULES – INPATIENT HOSPITAL SERVICES.

- (1) This section defines the reimbursement procedures and calculations for inpatient health care services by all hospitals. Hospital reimbursement is divided into two (2) groups based on type of admission (surgical or non-surgical (medical)) and length of stay (less than eight (8) days/over seven (7) days). Rehabilitation and Psychiatric hospitals are grouped separately.
- (2) General Information
 - (a) For each inpatient claim submitted, the provider shall assign a Diagnosis Related Group (DRG) code which appropriately reflects the patient's primary cause for hospitalization to determine average length of stay and for tracking purposes. Hospitals within each peer group are subject to a maximum amount per inpatient day.
 - (b) The maximum per diem rates to be used in calculating the reimbursement rate is as follows:

1.	Peer Group 1	\$1,800.00 Surgical adm for the first seven (7) days; 1,500.00 per day thereafter (surgical adm.) Includes Intensive Care (ICU) & Critical Care (CCU)
		1,500.00 Medical adm. for first seven (7) days; 1,250.000 per day thereafter (medical adm.)
2.	Peer Group 2	1,000.00 For the first seven (7) days; (Rehabilitation) 800.00 per day thereafter
3.	Peer Group 3	700.00 Psychiatric Hospitals (applicable to chemical dependency as well.)
 - (c) All trauma care at any licensed Level 1 Trauma Center shall be reimbursed at a maximum rate of \$3,000.00 per day for each day of patient stay.
 - (d) Surgical implants shall be reimbursed separately and in addition to the per diem hospital charges.

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1. Reimbursement for trauma inpatient hospital services shall be limited to the lesser of the maximum allowable as calculated by the appropriate per diem rate, or the hospital's billed charges minus any non-covered charges.
 2. Non-covered charges are: convenience items, charges for services not related to the work injury/illness services that were not certified by the payer or their representative as medically necessary.
 3. Additional reimbursement may be made in addition to the per diem for implantables (i.e. rods, pins, plates and joint replacements, etc.). The reimbursement for the implantables is limited to hospital's cost plus fifteen percent (15%) of invoice, up to a maximum of invoice plus \$1,000.00. Implantables shall be billed using the appropriate HCPCS codes, when available. Billing for implantables must be accompanied by an invoice when requested by the payer.
 4. The following items are not included in the per diem reimbursement to the facility and may be reimbursed separately. All of these items must be listed with the HCPCS code.
 - (i) Durable Medical Equipment
 - (ii) Orthotics and Prosthetics
 - (iii) Implantables
 - (iv) Ambulance Services
 - (v) Take home medications and supplies
 - (e) The above listed items will be reimbursed according to the Medical Cost Containment Program Rules and Medical Fee Schedule Rules payment limits. Items not listed in the fee schedule Rules will be reimbursed at the usual and customary rate, unless otherwise indicated herein.
 - (f) Per diem rates are all inclusive (with the exception of those items listed in 4 above). The services must be medically necessary and delivered at the appropriate level/site of service.
 - (g) The In-patient Hospital Fee Schedule allows for independent reimbursement on a case-by-case basis if the particular care exceeds the Stop-Loss Threshold.
- (3) Reimbursement Calculations
- (a) Explanation
 1. Each admission is assigned an appropriate DRG.
 2. The applicable Standard Per Diem Amount ("SPDA") is multiplied by the length of stay ("LOS") for that admission.

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3. The Workers' Compensation Reimbursement Amount ("WCRA") is the total amount of reimbursement to be made for that particular admission.

(b) Formula: $LOS \times SPDA = WCRA$

(c) Example: DRG 222: Knee Procedures W/O CC

Hospital Peer Group: 1-Surgical admission:

Maximum rate per day: \$1,800 first seven (7) days/\$1,500 per day each day thereafter

Number billed days: 9

Billed charges: \$15,600

Maximum Allowable Payment: \$15,600

(4) Stop-Loss Method

(a) Stop-loss is an independent reimbursement factor established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.

(b) Explanation

1. To be eligible for stop loss payment, the total Allowed Charges for a hospital admission must exceed the hospital maximum payment, as determined by the hospital maximum payment rate per day, by at least \$15,000.

2. This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.

3. Once the allowed charges reach the stop-loss threshold, reimbursement for all additional charges shall be made based on a stop-loss payment factor of 80%.

4. The additional charges are multiplied by the Stop-Loss Reimbursement Factor (SLRF) and added to the maximum allowable payment.

(c) Formula: $(\text{Additional Charges} \times \text{SLRF}) + \text{Maximum Allowable Payment} = \text{WCRA}$

(d) Example: DRG 222: Knee Procedures W/O CC

Hospital Peer Group: 1 –Surgical admission

Maximum rate per day: \$1,800 for first 7 days; 1,500 for 2 additional days

Number Billed Days: 9

Total Billed Charges: \$37,600.00

Maximum allowable payment for

Normal DRG stay \$15,600

Versus: billed charges \$37,600

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Amount Payable Before Stop-Loss,
Lower of Charge vs. Maximum Allowable..... \$15,600

Total difference, charges over and above maximum payments \$22,000

Difference over and above \$15,000 Stop-loss is \$7,000.00
Payable under Stop-loss (80% of 7,000.00)..... \$5,600.00

Total payment
due hospital: \$21,200.00 (15,600+5,600)

(5) Billing for Inpatient Admissions

All bills for inpatient institutional services should be submitted on the standard UB-82 (HCFA 1450) form or any revision to that form approved for use by the CMS.

Authority: T.C.A. §§ 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

0800-2-19-.04. PREAUTHORIZATION.

(1) Procedures For Requesting Preauthorization

- (a) The insurance carrier shall be liable for the reasonable and necessary medical costs relating to the health care treatments and services listed in subparagraph (g) of this Rule required to treat a compensable injury, when any of the following situations occur:
 - 1. the treating doctor, his/her designated representative, or injured employee has received preauthorization from the carrier prior to the health care treatments or services;
 - 2. the carrier has failed to communicate approval or denial of preauthorization within seven (7) business days of a provider's request for preauthorization; or
 - 3. when ordered by the Division.
- (b) The insurance carrier shall designate an accessible direct telephone number, and may also designate a facsimile number for use by the provider or the provider's designated representative or the injured employee to request preauthorization during normal business hours. The direct number shall be answered or the facsimile responded to, by the carrier's agent who is delegated to approve or deny requests for preauthorization, within the time limits established in subsection (d) of this section.
- (c) Prior to the date of proposed treatment or services, the provider or the provider's designated representative, shall notify the insurance carrier's delegated agent, by telephone or transmission of a facsimile, of the recommended treatment or service listed in subparagraph (g) of this Rule. Notification shall include the medical information to substantiate the need for the treatment or service recommended. If requested to do so by the carrier, the treating doctor shall also notify the insurance

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carrier of the location and estimated date of the recommended treatment or service, and the name of the health care provider performing the treatment or service, if other than the provider. Designated representative includes, but is not limited to, office staff, hospitals, etc.

- (d) Within seven (7) business days of the provider's request for preauthorization, the insurance carrier's delegated agent shall notify the provider or the provider's designated representative, by telephone or transmission of a facsimile, of the insurance carrier's decision to grant or deny preauthorization. Failure of the carrier to communicate its approval or denial of authorization within seven (7) business days of a provider's request for preauthorization shall automatically be deemed an approval of the preauthorization request. When the insurance carrier approves preauthorization, the insurance carrier shall send written approval, or if denying preauthorization, shall send documentation identifying the reasons for denial. Notification shall be sent to the injured employee, the injured employee's representative if known, and the provider or the provider's designated representative, within 24 hours after notification of denial or approval.
- (e) The insurance carrier shall maintain accurate records to reflect information regarding the preauthorization request and approval/denial process.
- (f) If a dispute arises over denial of preauthorization by the insurance carrier, the doctor or the injured employee may file a Request for Assistance with a Benefit Review Specialist.
- (g) The health care treatments and services requiring preauthorization are: all nonemergency hospitalizations and non-emergency transfers between facilities.

Authority: T.C.A. §§ 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

0800-2-19-.05 OTHER SERVICES

- (1) Pharmacy Services
 - (a) Pharmaceutical services rendered as part of inpatient care are considered inclusive within the inpatient fee schedule and shall not be reimbursed separately.
 - (b) All retail pharmaceutical services rendered shall be reimbursed in accordance with the Pharmacy Schedule Guidelines.
- (2) Professional Services
 - (a) All non-institutional professional services will be reimbursed in accordance with the Division's Medical Cost Containment Program Rules and Medical Fee Schedule Rules which must be used in conjunction with these Rules.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204, 50-6-205 (Supp. 2004).

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0800-2-19-.06 PENALTIES FOR VIOLATIONS OF FEE SCHEDULES

- (1) Providers shall not accept and employers or carriers shall not pay any amount for health care services provided for the treatment of a covered injury or illness or for any other services encompassed within the Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules. Any provider accepting and any employer or carrier paying an amount in excess of the Division's Medical Cost Containment Program Rules, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules shall be in violation of these Rules and may, at the Commissioner's discretion, be subject to civil penalties of ten thousand dollars (\$10,000.00) per violation for each violation, which may be assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, whenever a pattern or practice of such activity is found. At the discretion of the Commissioner, the Commissioner's Designee, or an agency member appointed by the Commissioner, such provider may also be reported to the appropriate certifying board, and may be subject to exclusion from participating in providing care under the Act. Any other violation of the Medical Cost Containment Program Rules, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules shall subject the alleged violator(s) to a civil penalty of not less than one hundred dollars (\$100.00) nor more than ten thousand dollars (\$10,000.00) per violation, at the discretion of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner.
- (2) A provider, employer or carrier found to be in violation of these Rules, whether a civil penalty is assessed or not, may request a contested case hearing by requesting such hearing in writing within fifteen (15) days of issuance of a Notice of Violation and, if applicable, the notice of assessment of civil penalties.
- (3) The request for a hearing shall be made to the Division in writing by an employer, carrier or provider which has been notified of its violation of these Rules, and if applicable, assessed a civil penalty.
- (4) Any request for a hearing shall be filed with the Division within fifteen (15) calendar days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty. Failure to file a request for a hearing within fifteen (15) calendar days of the date of issuance of a Notice of Violation shall result in the decision of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner becoming a final order and not subject to further review.
- (5) The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner shall have the authority to hear the matter as a contested case and determine if any civil penalty assessed should have been assessed.
- (6) Upon receipt of a timely filed request for a hearing, the Commissioner shall issue a Notice of Hearing to all interested parties.

Authority: T.C.A. §§ 50-6-204, 50-6-205 (Supp. 2004), 50-6-233 (Repl. 1999).

The notice of rulemaking set out herein was properly filed in the Department of State on the 20th day of July, 2005. (07-23)

RULEMAKING HEARINGS

BOARD OF MEDICAL EXAMINERS - 0880 DIVISION OF HEALTH RELATED BOARDS

There will be a hearing before the Tennessee Board of Medical Examiners to consider the promulgation of amendments to rules pursuant to T.C.A. §§ 4-5-202, 4-5-204, 63-6-101, 63-6-204, 63-6-214, 63-6-215, 63-6-235, and Public Chapters 250 and 467 of the Public Acts of 2005. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Magnolia Room of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 8:45 a.m. (CDT) on the 20th day of September, 2005.

Any individuals with disabilities who wish to participate in these proceedings (review these filings) should contact the Department of Health, Division of Health Related Boards to discuss any auxiliary aids or services needed to facilitate such participation or review. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date such party intends to review such filings), to allow time for the Division to determine how it may reasonably provide such aid or service. Initial contact may be made with the ADA Coordinator at the Division of Health Related Boards, First Floor, Cordell Hull Building, 425 Fifth Avenue North, Nashville, TN 37247-1010, (615) 532-4397.

For a copy of the entire text of this notice of rulemaking hearing contact:

Jerry Kosten, Regulations Manager, Division of Health Related Boards, 425 Fifth Avenue North, First Floor, Cordell Hull Building, Nashville, TN 37247-1010, (615) 532-4397.

SUBSTANCE OF PROPOSED RULES

AMENDMENTS

Rule 0880-2-.14 Specially Regulated Areas and Aspects of Medical Practice, is amended by adding the following language as new paragraph (11):

- (11) Use of Titles - Any person who possesses a valid, unsuspended and unrevoked license issued by the Board has the right to use the title "Medical Doctor" or "M.D." and to practice medicine, as defined in T.C.A. §§ 63-6-204. Violation of this rule regarding use of titles shall constitute unprofessional conduct and subject the licensee to disciplinary action.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-6-101, 63-6-204, 63-6-214, 63-6-215, and Public Chapter 467 of the Public Acts of 2005.

Rule 0880-2-.22 Free Health Clinic, Inactive Pro Bono and Volunteer Practice Requirements, is amended by adding the following language as new paragraph (2) and renumbering the remaining paragraphs accordingly:

- (2) Special Volunteer License for Out-of-State Practice.
 - (a) Any physician whose license to practice medicine in Tennessee is in retired or inactive status and who has not been disciplined by any medical licensure board may receive a "Special Volunteer License for Out-of-State Practice," which will entitle the licensee to practice without remuneration at benevolent or humanitarian service projects locations outside of the state by doing the following:

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1. Comply with the provisions of parts (1) (a) 1., (1) (a) 2. and (1) (a) 3. of this rule; and
 2. Submit to the Board's administrative office the location and details of the benevolent or humanitarian service projects at which the licensee intends to practice.
- (b) The provisions of subparagraphs (1) (b) and (1) (d) of this rule are applicable to Special Volunteer Licenses for Out-of-State Practice.
- (c) Unless appropriately licensed elsewhere, a physician holding a Special Volunteer License for Out-of-State Practice may not practice medicine anywhere other than at the benevolent or humanitarian service projects specified in the application.

Authority: *T.C.A. §§ 4-5-202, 4-5-204, 63-6-101, 63-6-235, and Public Chapter 250 of the Public Acts of 2005.*

The notice of rulemaking set out herein was properly filed in the Department of State on the 20th day of July, 2005. (07-20)

RULEMAKING HEARINGS

BOARD OF MEDICAL EXAMINERS - 0880 COMMITTEE ON PHYSICIAN ASSISTANTS

There will be a hearing before the Tennessee Board of Medical Examiners' Committee on Physician Assistants to consider the promulgation of amendments to rules pursuant to T.C.A. §§ 4-5-202, 4-5-204, 63-1-138, 63-6-101, 63-19-104, 63-19-106, 63-19-107, 63-19-111, 63-19-114, 63-19-201, 63-19-210, 68-3-512, and Public Chapters 12, 234, 333, 434, and 467 of the Public Acts of 2005. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Magnolia Room of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 2:30 p.m. (CDT) on the 22nd day of September, 2005.

Any individuals with disabilities who wish to participate in these proceedings (review these filings) should contact the Department of Health, Division of Health Related Boards to discuss any auxiliary aids or services needed to facilitate such participation or review. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date such party intends to review such filings), to allow time for the Division to determine how it may reasonably provide such aid or service. Initial contact may be made with the ADA Coordinator at the Division of Health Related Boards, First Floor, Cordell Hull Building, 425 Fifth Avenue North, Nashville, TN 37247-1010, (615) 532-4397.

For a copy of the entire text of this notice of rulemaking hearing contact:

Jerry Kosten, Regulations Manager, Division of Health Related Boards, 425 Fifth Avenue North, First Floor, Cordell Hull Building, Nashville, TN 37247-1010, (615) 532-4397.

SUBSTANCE OF PROPOSED RULES

AMENDMENTS

Rule 0880-3-.02 Scope of Practice, is amended by adding the following language as new paragraph (2):

- (2) Determinations and pronouncements of death shall be governed by T.C.A. § 68-3-512.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-6-101, 63-19-104, 63-19-106, 68-3-512, and Public Chapter 333 of the Public Acts of 2005.

Rule 0880-3-.15 Disciplinary Grounds, Actions, and Civil Penalties, is amended by adding the following language as new subparagraph (1) (v):

- (1) (v) Violation of the use of title statute, T.C.A. § 63-19-114.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-6-101, 63-19-104, 63-19-111, 63-19-114, and Public Chapter 467 of the Public Acts of 2005.

Rule 0880-3-.19 Committee Members, Officers, Consultants, Records and Declaratory Orders, is amended by deleting the catchline in its entirety and substituting instead the following language, and is further amended by adding the following language as new paragraph (10), so that as amended, the new catchline and the new paragraph (10) shall read:

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0880-3-.19 COMMITTEE MEMBERS, OFFICERS, CONSULTANTS, RECORDS, DECLARATORY ORDERS AND SCREENING PANELS

- (10) Screening Panels - The Committee adopts, as if fully set out herein, rule 1200-10-1-.13, of the Division of Health Related Boards and as it may from time to time be amended, as its rule governing the screening panel process.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-1-138, 63-6-101, 63-19-104, and Public Chapter 234 of the Public Acts of 2005.

Rule 0880-3-.20 Advertising, is amended by deleting the language of the rule in its entirety and is further amended by adding the following language as new paragraphs (1) through (6):

- (1) Policy Statement. The lack of sophistication on the part of many of the public concerning medical services, the importance of the interests affected by the choice of a physician assistant and the foreseeable consequences of unrestricted advertising by physician assistants which is recognized to pose special possibilities for deception, require that special care be taken by physician assistants to avoid misleading the public. The physician assistant must be mindful that the benefits of advertising depend upon its reliability and accuracy. Since advertising by physician assistants is calculated and not spontaneous, reasonable regulation designed to foster compliance with appropriate standards serves the public interest without impeding the flow of useful, meaningful, and relevant information to the public.
- (2) Definitions
- (a) Advertisement. Informational communication to the public in any manner designed to attract public attention to the practice of a physician assistant who is licensed to practice in Tennessee.
- (b) Licensee - Any person holding a license to practice as a physician assistant in the State of Tennessee. Where applicable this shall include partnerships and/or corporations.
- (c) Material Fact - Any fact which an ordinary reasonable and prudent person would need to know or rely upon in order to make an informed decision concerning the choice of practitioners to serve his or her particular needs.
- (d) Bait and Switch Advertising - An alluring but insincere offer to sell a product or service which the advertiser in truth does not intend or want to sell. Its purpose is to switch consumers from buying the advertised service or merchandise, in order to sell something else, usually for a higher fee or on a basis more advantageous to the advertiser.
- (e) Discounted Fee - Shall mean a fee offered or charged by a person or product or service that is less than the fee the person or organization usually offers or charges for the product or service. Products or services expressly offered free of charge shall not be deemed to be offered at a "discounted fee".
- (3) Advertising Fees and Services
- (a) Fixed Fees. Fixed fees may be advertised for any service. It is presumed unless otherwise stated in the advertisement that a fixed fee for a service shall include the cost of all professional recognized components within generally accepted standards that are required to complete the service.

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- (b) Range of Fees. A range of fees may be advertised for services and the advertisement must disclose the factors used in determining the actual fee, necessary to prevent deception of the public.
 - (c) Discount Fees. Discount fees may be advertised if:
 - 1. The discount fee is in fact lower than the licensee's customary or usual fee charged for the service; and
 - 2. The licensee provides the same quality and components of service and material at the discounted fee that are normally provided at the regular, non-discounted fee for that service.
 - (d) Related Services and Additional Fees. Related services which may be required in conjunction with the advertised services for which additional fees will be charged must be identified as such in any advertisement.
 - (e) Time Period of Advertised Fees. Advertised fees shall be honored for those seeking the advertised services during the entire time period stated in the advertisement whether or not the services are actually rendered or completed within that time. If no time period is stated in the advertisement of fees, the advertised fee shall be honored for thirty (30) days from the last date of publication or until the next scheduled publication whichever is later whether or not the services are actually rendered or completed within that time.
- (4) Advertising Content. The following acts or omissions in the context of advertisement by any licensee shall constitute unethical and unprofessional conduct, and subject the licensee to disciplinary action pursuant to Rule 0880-3-.15
- (a) Claims that the services performed, personnel employed, materials or office equipment used are professionally superior to that which is ordinarily performed, employed, or used, or that convey the message that one licensee is better than another when superiority of services, personnel, materials or equipment cannot be substantiated.
 - (b) The misleading use of an unearned or non-health degree in any advertisement.
 - (c) Promotion of professional services which the licensee knows or should know is beyond the licensee's ability to perform.
 - (d) Techniques of communication which intimidate, exert undue pressure or undue influence over a prospective client.
 - (e) Any appeals to an individual's anxiety in an excessive or unfair manner.
 - (f) The use of any personal testimonial attesting to a quality of competency of a service or treatment offered by a licensee that is not reasonably verifiable.
 - (g) Utilization of any statistical data or other information based on past performances for prediction of future services, which creates an unjustified expectation about results that the licensee can achieve.
 - (h) The communication of personal identifiable facts, data, or information about a patient without first obtaining patient consent.

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- (i) Any misrepresentation of a material fact.
- (j) The knowing suppression, omission or concealment of any materials fact or law without which the advertisement would be deceptive or misleading.
- (k) Statements concerning the benefits or other attributes of medical procedures or products that involve significant risks without including:
 - 1. A realistic assessment of the safety and efficiency of those procedures or products; and
 - 2. The availability of alternatives; and
 - 3. Where necessary to avoid deception, descriptions or assessment of the benefits or other attributes of those alternatives.
- (l) Any communication which creates an unjustified expectation concerning the potential results of any treatment.
- (m) Failure to comply with the rules governing advertisement of fees and services, or advertising records.
- (n) The use of “bait and switch” advertisements. Where the circumstances indicate “bait and switch” advertising, the Board may require the licensee to furnish data or other evidence pertaining to those sales at the advertised fee as well as other sales.
- (o) Misrepresentation of a licensee’s credentials, training, experience, or ability.
- (p) Failure to include the corporation, partnership or individual licensee’s name, address, and telephone number in any advertisement. Any corporation, partnership or association which advertises by use of a trade name or otherwise fails to list all licensees practicing at a particular location shall:
 - 1. Upon request provide a list of all licensees practicing at that location; and
 - 2. Maintain and conspicuously display at the licensee’s office, a directory listing all licensees practicing at that location.
- (q) Failure to disclose the fact of giving compensation or anything of value to representatives of the press, radio, television or other communicative medium in anticipation of or in return for any advertisement (for example, newspaper article) unless the nature, format or medium of such advertisement make the fact of compensation apparent.
- (r) After thirty (30) days of the licensee’s departure, the use of the name of any licensee formerly practicing at or associated with any advertised location or on office signs or buildings. This rule shall not apply in the case of a retired or deceased former associate who practiced in association with one or more of the present occupants if the status of the former associate is disclosed in any advertisement or sign.
- (s) Stating or implying that a certain licensee provides all services when any such services are performed by another licensee.

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- (t) Directly or indirectly offering, giving, receiving, or agreeing to receive any fee or other consideration to or from a third party for the referral of a patient in connection with the performance of professional services.
- (5) Advertising Records and Responsibility
 - (a) Each licensee who is a principal partner, or officer of a firm or entity identified in any advertisement, is jointly and severally responsible for the form and content of any advertisement. This provision shall also include any licensed professional employees acting as an agent of such firm or entity.
 - (b) Any and all advertisements are presumed to have been approved by the licensee named therein.
 - (c) A recording of every advertisement communicated by electronic media, and a copy of every advertisement communicated by print media, and a copy of any other form of advertisement shall be retained by the licensee for a period of two (2) years from the last date of broadcast or publication and be made available for review upon request by the Committee or its designee.
 - (d) At the time any type of advertisement is placed, the licensee must possess and rely upon information which, when produced, would substantiate the truthfulness of any assertion, omission or representation of material fact set forth in the advertisement or public information.
- (6) Severability. It is hereby declared that the sections, clauses, sentences and part of these rules are severable, are not matters of mutual essential inducement, and any of them shall be rescinded if these rules would otherwise be unconstitutional or ineffective. If any one or more sections, clauses, sentences or parts shall for any reason be questioned in court, and shall be adjudged unconstitutional or invalid, such judgment shall not affect, impair or invalidate the remaining provisions thereof, but shall be confined in its operation to the specific provision or provisions so held unconstitutional or invalid, and the inapplicability or invalidity of any section, clause, sentence or part in any one or more instance shall not be taken to affect or prejudice in any way its applicability or validity in any other instance.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-6-101, 63-19-104, 63-19-114, and Public Chapter 467 of the Public Acts of 2005.

Rule 0880-3-.21 Prescription Writing, is amended by deleting paragraph (1) in its entirety and substituting instead the following language, so that as amended, the new paragraph (1) shall read:

- (1) Prescription writing shall be governed by Tennessee Code Annotated, Section 63-19-107 and Title 53, Chapter 10, Part 2.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-6-101, 63-19-104, 63-19-107, and Public Chapters 12 and 434 of the Public Acts of 2005.

Rule 0880-10-.15 Disciplinary Grounds, Actions, and Civil Penalties, is amended by adding the following language as new subparagraph (1) (v):

- (1) (v) Violation of the correct title statute, T.C.A. § 63-19-210.

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Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-6-101, 63-19-104, 63-19-111, 63-19-201, 63-19-210, and Public Chapter 467 of the Public Acts of 2005.

Rule 0880-10-.19 Committee Members, Officers, Consultants, Records and Declaratory Orders, is amended by deleting the catchline in its entirety and substituting instead the following language, and is further amended by adding the following language as new paragraph (10), so that as amended, the new catchline and the new paragraph (10) shall read:

0880-10-.19 COMMITTEE MEMBERS, OFFICERS, CONSULTANTS, RECORDS, DECLARATORY ORDERS AND SCREENING PANELS

- (10) Screening Panels - The Committee adopts, as if fully set out herein, rule 1200-10-1-.13, of the Division of Health Related Boards and as it may from time to time be amended, as its rule governing the screening panel process.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-1-138, 63-6-101, 63-19-104, 63-19-201, and Public Chapter 234 of the Public Acts of 2005.

Rule 0880-10-.20 Advertising, is amended by deleting the language of the rule in its entirety and is further amended by adding the following language as new paragraphs (1) through (6):

- (1) Policy Statement. The lack of sophistication on the part of many of the public concerning medical services, the importance of the interests affected by the choice of an orthopedic physician assistant and the foreseeable consequences of unrestricted advertising by orthopedic physician assistants which is recognized to pose special possibilities for deception, require that special care be taken by orthopedic physician assistants to avoid misleading the public. The orthopedic physician assistant must be mindful that the benefits of advertising depend upon its reliability and accuracy. Since advertising by orthopedic physician assistants is calculated and not spontaneous, reasonable regulation designed to foster compliance with appropriate standards serves the public interest without impeding the flow of useful, meaningful, and relevant information to the public.
- (2) Definitions
 - (a) Advertisement. Informational communication to the public in any manner designed to attract public attention to the practice of an orthopedic physician assistant who is licensed to practice in Tennessee.
 - (b) Licensee - Any person holding a license to practice as an orthopedic physician assistant in the State of Tennessee. Where applicable this shall include partnerships and/or corporations.
 - (c) Material Fact - Any fact which an ordinary reasonable and prudent person would need to know or rely upon in order to make an informed decision concerning the choice of practitioners to serve his or her particular needs.
 - (d) Bait and Switch Advertising - An alluring but insincere offer to sell a product or service which the advertiser in truth does not intend or want to sell. Its purpose is to switch consumers from buying the advertised service or merchandise, in order to sell something else, usually for a higher fee or on a basis more advantageous to the advertiser.

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- (e) Discounted Fee - Shall mean a fee offered or charged by a person or product or service that is less than the fee the person or organization usually offers or charges for the product or service. Products or services expressly offered free of charge shall not be deemed to be offered at a "discounted fee".
- (3) Advertising Fees and Services
- (a) Fixed Fees. Fixed fees may be advertised for any service. It is presumed unless otherwise stated in the advertisement that a fixed fee for a service shall include the cost of all professional recognized components within generally accepted standards that are required to complete the service.
 - (b) Range of Fees. A range of fees may be advertised for services and the advertisement must disclose the factors used in determining the actual fee, necessary to prevent deception of the public.
 - (c) Discount Fees. Discount fees may be advertised if:
 - 1. The discount fee is in fact lower than the licensee's customary or usual fee charged for the service; and
 - 2. The licensee provides the same quality and components of service and material at the discounted fee that are normally provided at the regular, non-discounted fee for that service.
 - (d) Related Services and Additional Fees. Related services which may be required in conjunction with the advertised services for which additional fees will be charged must be identified as such in any advertisement.
 - (e) Time Period of Advertised Fees. Advertised fees shall be honored for those seeking the advertised services during the entire time period stated in the advertisement whether or not the services are actually rendered or completed within that time. If no time period is stated in the advertisement of fees, the advertised fee shall be honored for thirty (30) days from the last date of publication or until the next scheduled publication whichever is later whether or not the services are actually rendered or completed within that time.
- (4) Advertising Content. The following acts or omissions in the context of advertisement by any licensee shall constitute unethical and unprofessional conduct, and subject the licensee to disciplinary action pursuant to Rule 0880-3-.15
- (a) Claims that the services performed, personnel employed, materials or office equipment used are professionally superior to that which is ordinarily performed, employed, or used, or that convey the message that one licensee is better than another when superiority of services, personnel, materials or equipment cannot be substantiated.
 - (b) The misleading use of an unearned or non-health degree in any advertisement.
 - (c) Promotion of professional services which the licensee knows or should know is beyond the licensee's ability to perform.
 - (d) Techniques of communication which intimidate, exert undue pressure or undue influence over a prospective client.

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- (e) Any appeals to an individual's anxiety in an excessive or unfair manner.
- (f) The use of any personal testimonial attesting to a quality of competency of a service or treatment offered by a licensee that is not reasonably verifiable.
- (g) Utilization of any statistical data or other information based on past performances for prediction of future services, which creates an unjustified expectation about results that the licensee can achieve.
- (h) The communication of personal identifiable facts, data, or information about a patient without first obtaining patient consent.
- (i) Any misrepresentation of a material fact.
- (j) The knowing suppression, omission or concealment of any material fact or law without which the advertisement would be deceptive or misleading.
- (k) Statements concerning the benefits or other attributes of medical procedures or products that involve significant risks without including:
 - 1. A realistic assessment of the safety and efficiency of those procedures or products; and
 - 2. The availability of alternatives; and
 - 3. Where necessary to avoid deception, descriptions or assessment of the benefits or other attributes of those alternatives.
- (l) Any communication which creates an unjustified expectation concerning the potential results of any treatment.
- (m) Failure to comply with the rules governing advertisement of fees and services, or advertising records.
- (n) The use of "bait and switch" advertisements. Where the circumstances indicate "bait and switch" advertising, the Board may require the licensee to furnish data or other evidence pertaining to those sales at the advertised fee as well as other sales.
- (o) Misrepresentation of a licensee's credentials, training, experience, or ability.
- (p) Failure to include the corporation, partnership or individual licensee's name, address, and telephone number in any advertisement. Any corporation, partnership or association which advertises by use of a trade name or otherwise fails to list all licensees practicing at a particular location shall:
 - 1. Upon request provide a list of all licensees practicing at that location; and
 - 2. Maintain and conspicuously display at the licensee's office, a directory listing all licensees practicing at that location.
- (q) Failure to disclose the fact of giving compensation or anything of value to representatives of the press, radio, television or other communicative medium in anticipation of or in return

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for any advertisement (for example, newspaper article) unless the nature, format or medium of such advertisement make the fact of compensation apparent.

- (r) After thirty (30) days of the licensee's departure, the use of the name of any licensee formerly practicing at or associated with any advertised location or on office signs or buildings. This rule shall not apply in the case of a retired or deceased former associate who practiced in association with one or more of the present occupants if the status of the former associate is disclosed in any advertisement or sign.
 - (s) Stating or implying that a certain licensee provides all services when any such services are performed by another licensee.
 - (t) Directly or indirectly offering, giving, receiving, or agreeing to receive any fee or other consideration to or from a third party for the referral of a patient in connection with the performance of professional services.
- (5) Advertising Records and Responsibility
- (a) Each licensee who is a principal partner, or officer of a firm or entity identified in any advertisement, is jointly and severally responsible for the form and content of any advertisement. This provision shall also include any licensed professional employees acting as an agent of such firm or entity.
 - (b) Any and all advertisements are presumed to have been approved by the licensee named therein.
 - (c) A recording of every advertisement communicated by electronic media, and a copy of every advertisement communicated by print media, and a copy of any other form of advertisement shall be retained by the licensee for a period of two (2) years from the last date of broadcast or publication and be made available for review upon request by the Committee or its designee.
 - (d) At the time any type of advertisement is placed, the licensee must possess and rely upon information which, when produced, would substantiate the truthfulness of any assertion, omission or representation of material fact set forth in the advertisement or public information.
- (6) Severability. It is hereby declared that the sections, clauses, sentences and part of these rules are severable, are not matters of mutual essential inducement, and any of them shall be rescinded if these rules would otherwise be unconstitutional or ineffective. If any one or more sections, clauses, sentences or parts shall for any reason be questioned in court, and shall be adjudged unconstitutional or invalid, such judgment shall not affect, impair or invalidate the remaining provisions thereof, but shall be confined in its operation to the specific provision or provisions so held unconstitutional or invalid, and the inapplicability or invalidity of any section, clause, sentence or part in any one or more instance shall not be taken to affect or prejudice in any way its applicability or validity in any other instance.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-6-101, 63-19-104, 63-19-201, and Public Chapter 467 of the Public Acts of 2005.

The notice of rulemaking set out herein was properly filed in the Department of State on the 8th day of July, 2005. (07-10)

RULEMAKING HEARINGS

DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES - 0940 OFFICE OF LICENSURE

There will be a hearing before the Tennessee Department of Mental Health and Developmental Disabilities, Office of Licensure to consider the promulgation of new rules and repeal of rules pursuant to T.C.A. §§ 4-4-103, 4-5-202, and 204, and 33-1-302, 305, and 309, 33-2-301 and 302, and 33-2-404. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Tennessee-B Room of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 1:00 p.m., Central Daylight Time on the 20th day of September, 2005.

Individuals with disabilities who wish to participate in these proceedings or review these filings should contact the Tennessee Department of Mental Health and Developmental Disabilities, to discuss any auxiliary aids or services needed to facilitate such participation or review. Such contact may be in person, by writing, telephone, or other means, and should be made no less than ten (10) days prior to the scheduled meeting date or the date such party intends to review such filings, to allow time to provide such aid or service. Contact the Tennessee Department of Mental Health and Developmental Disabilities ADA Coordinator, Joe Swinford, 3rd Floor, Cordell Hull Building, 425 Fifth Avenue North, Nashville, TN 37243. Mr. Swinford's telephone number is (615) 532-6700; the department's TDD is (615) 532-6612. Copies of the notice are available from the Tennessee Department of Mental Health and Developmental Disabilities in alternative format upon request.

For a copy of the entire text of this notice of rulemaking hearing contact:

Glenda Rogers, Office of Licensure, Department of Mental Health and Developmental Disabilities, 425 Fifth Avenue North, Fifth Floor, Cordell Hull Building, Nashville, TN 37243-1010, (615) 532-6590.

SUBSTANCE OF PROPOSED RULES

NEW RULES

CHAPTER 0940-5-20

MINIMUM PROGRAM REQUIREMENTS FOR MENTAL RETARDATION DAY SERVICES AND FACILITIES

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0940-5-20-.01 DEFINITION. Mental Retardation Day Services and Facilities - A non-residential service which provides supervision, assistance with the activities of daily living, or training to improve, maintain or prevent the loss of independence, skills and functions. Included are services that enable service recipients to sustain supported or competitive employment, participate in community activities and utilize community resources, participate in retirement activities, and training to acquire skills as specified in the plan of care. Services occur on a job site, in community locations, in the service recipient's home or in a facility for day services for individuals with disabilities.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-20-.02 APPLICATION OF RULES.

- (1) The licensee of day services and facilities must comply with the following rules:
 - (a) Applicable life safety rules for Health Care Occupancy Classification when services occur in a facility serving four (4) or more persons who are not capable of self-preservation;
 - (b) Applicable life safety rules for industrial, or business, or day care, or educational occupancy classifications depending on the services provided or the use of the facility;
 - (c) Adequacy of Program Environment and Ancillary Services Rules;
 - (d) Minimum Program Requirements for All Program Rules;
 - (e) Minimum Program Requirements for Mental Retardation Day Services and Facilities; and
 - (f) Applicable rules for services provided to one (1) or more mobile non-ambulatory person(s).

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-20-.03 HEALTH, SAFETY AND WELFARE SAFEGUARDS IN DAY SERVICES AND FACILITIES.

- (1) The licensee must provide assistance to service recipients in receiving qualified dental, medical, nursing, medications prescribed by a physician, and care for emergencies, during day services hours.
- (2) The licensee must ensure that each service recipient receives an annual physical examination (unless less often is indicated by the service recipient's physician) which includes routine screenings (such as vision and hearing) and laboratory examinations (such as Pap smear, mammogram, prostate screening, and blood work) as determined necessary by the physician and special studies where the index of suspicion is high.

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- (3) The licensee must require that a service recipient receive immunizations as required by the Tennessee Department of Health unless contraindicated by a doctor's written orders.
- (4) The licensee must ensure that the service recipient has had a physical examination within the twelve (12) months prior to admission or within thirty (30) days after admission.
- (5) The licensee must ensure that employees practice infection control procedures that will protect service recipients from infectious diseases.
- (6) The licensee must assist the service recipient/legal representative with planning for qualified dental, medical, nursing, medications prescribed by a physician, and care for emergencies, during day services hours.
- (7) The licensee must ensure that appropriate corrective actions have been taken in response to substantiated abuse or neglect.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-20-.04 PERSONNEL AND STAFFING REQUIREMENTS FOR DAY SERVICES AND FACILITIES.

- (1) The licensee must provide one (1) direct services staff member for the first one (1) to ten (10) service recipients supported. One (1) additional direct services staff member must be provided for the next increment of (11) to fifteen (15) service recipients. When more than twenty (20) service recipients are served, one (1) additional direct services staff member must be provided for each additional increment of one (1) to twenty (20) service recipients present.
- (2) All employees must be screened for tuberculosis according to the procedures of the Tennessee Department of Health, or receive a tuberculosis skin test or chest X-ray before working directly with service recipients. Documentation must be maintained in the employee's personnel file.
- (3) The licensee must document that the Hepatitis B vaccine is made available to direct service employees.
- (4) Employees must be provided with a basic orientation in the specific needs of a service recipient prior to being assigned to work with him/her.
- (5) The licensee must provide at all times at least one (1) staff member who is certified in First Aid, Cardiopulmonary Resuscitation (CPR), and the Heimlich maneuver.
- (6) All staff must receive training in detection, reporting and prevention of abuse. This training must be documented in the staff record.
- (7) All professional services must be provided by persons duly licensed or certified to practice their profession in the State of Tennessee.
- (8) Service recipients must never be left unattended unless otherwise specified in the individual support plan. Approval by appropriate staff must be documented in the service recipient's record.

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Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-20-.05 RECORD REQUIREMENTS FOR DAY SERVICES AND FACILITIES. The licensee must ensure that each individual's record contains the following information:

- (1) A recent photograph and a description of the service recipient;
- (2) The service recipient's social security number;
- (3) The service recipient's legal competency status, including the name of the guardian/conservator, if applicable;
- (4) The service recipient's source of financial support, including social security, veteran's benefit and insurance;
- (5) The source of coverage for medical care cost;
- (6) The name, address and telephone number of the physician or health agency providing medical services;
- (7) Documentation of significant behavior incidents and of actions taken while the service recipient is in the care of the licensee;
- (8) Documentation of the use of restrictive behavior support techniques while the service recipient is in the care of the licensee;
- (9) Written accounts of all monies received and disbursed on behalf of the service recipient; and
- (10) Documentation of all drugs prescribed or administered by the licensee which indicates date prescribed, type, dosage, frequency, amount, reason and side effects;
- (11) Documentation of medical problems, accidents, seizures and illnesses and treatments rendered for such medical problems, accidents, seizures and illnesses while the service recipient is in the care of the licensee;
- (12) A discharge summary which states the date of discharge, reasons for discharge, and referral for other services, if appropriate.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-20-.06 MEDICATION ADMINISTRATION IN DAY SERVICES AND FACILITIES.

- (1) The level of supervision during the administration of medication is commensurate with the service recipient's capability.
- (2) When medications are administered by support staff, the licensee must:

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- (a) Ensure that if service recipients are not capable of self-administration of medication, the medication is only administered by personnel who are licensed or certified to administer medication in the State of Tennessee;
- (b) Ensure that prescription medications are taken only by service recipients for whom they are prescribed;
- (c) Provide storage for medications in a locked container that ensures proper conditions of security and sanitation and prevents accessibility by any unauthorized person;
- (d) Assure the disposal of discontinued and outdated medications and containers with worn, illegible or missing labels;
- (e) Report all medication errors, reactions or suspected overmedication to the practitioner who prescribed the medication; and
- (f) Maintain documentation of all prescription medications taken by service recipients, including the name of the medication, name of prescribing physician, date prescribed, purpose, dosage, frequency and side effects.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-20-.07 VOCATIONAL SERVICES IN DAY SERVICES AND FACILITIES. When vocational services are provided, the licensee must ensure that work is provided is dignified and not demeaning or degrading to the service recipient. Work activities must be challenging to the capabilities of the service recipient and result in a sense of accomplishment and productivity.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-20-.08 SUPPORTS AND SERVICES IN DAY SERVICES AND FACILITIES.

- (1) There is ongoing documentation which includes the type of service, the activities in which a service recipient is involved while participating, the purpose of the activities, and how they relate to the service recipient's individualized plan.
- (2) Each Day Services program has the appropriate work center (sheltered workshop) certificate issued by the US Department of Labor when applicable.
- (3) Service recipients engage in activities throughout the day that are based on each service recipient's preferences and interests.
- (4) The physical and nutritional needs of service recipients are addressed as needed.
- (5) Service recipients who have eating/swallowing problems are identified and supported.
- (6) Special diets and mealtime practices as recommended by practitioners are implemented.

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- (7) Service recipients have access to prescribed adapted equipment and/or assistive technology to facilitate proper seating and alignment, body control and functional participation in home, leisure and community activities.
- (8) Equipment is monitored to determine proper fit, working order, and need for repair.
- (9) Equipment storage is available.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-20-.09 PERSONAL CARE PROVISIONS IN DAY SERVICES AND FACILITIES.

- (1) The licensee provides service recipients with assistance and support, as needed, with health, hygiene and grooming practices in a private and dignified manner.
- (2) The licensee provides service recipients with assistance and support in the use of dental appliances, eyeglasses and hearing aids, and other therapeutic equipment.
- (3) Staff must be responsible for the implementation of the orders of a physician including recuperative procedures subsequent to a service recipient's illness or injury.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-20-.10 ASSESSMENT REQUIREMENTS FOR DAY SERVICES AND FACILITIES. The following assessments must be completed prior to developing the individual support plan:

- (1) An assessment of current functioning in such areas as adaptive behavior and independent living skills;
- (2) A basic medical history and information and determination of the necessity of a medical evaluation and a copy, where applicable, of the results of the medical evaluation;
- (3) A six-month history of prescription, and non-prescription drugs, and alcohol and substance abuse history; and
- (4) An existing psychological assessment on file which is updated as recommended.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-20-.11 INDIVIDUAL SUPPORT PLAN REQUIREMENTS FOR DAY SERVICES AND FACILITIES. The licensee must ensure that a written individual support plan (ISP) is provided and implemented for each service recipient within thirty (30) day of enrollment. The ISP must include the following:

- (1) The service recipient's name;
- (2) The date of plan development;

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- (3) Goals and objectives which are related to the specific needs and preferences which are to be addressed;
- (4) Interventions that address specific goals and objectives, identify staff responsible for interventions and planned frequency of contacts;
- (5) The licensee must maintain documentation that supports the implementation and results of the service recipient's plan;
- (6) Signature(s) of staff who attend planning meetings and the names of the primary staff responsible for its implementation, and
- (7) Signature of the service recipient (and/or conservator, legal custodian, or attorney in-fact) or documentation of reasons for refusal to sign and/or inability to participate in ISP development.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-20-.12 INDIVIDUAL SUPPORT PLAN MONITORING IN DAY SERVICES AND FACILITIES.

- (1) A review of the service recipient's response to the plan in achieving goals and meeting his/her needs must be documented monthly.
- (2) The individual support plan must be reviewed annually and revised as indicated.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-20-.13 REQUIREMENTS FOR THE USE OF RESTRICTED BEHAVIOR INTERVENTIONS IN DAY SERVICES AND FACILITIES.

- (1) The licensee ensures that restricted behavior interventions are not provided until unrestricted interventions have been systematically tried or considered and have been determined to be inappropriate or otherwise contraindicated.
- (2) The licensee ensures that restricted behavior interventions are only provided through an approved written intervention plan.
- (3) If restricted interventions are provided, the written intervention plan must:
 - (a) be based upon a functional assessment;
 - (b) utilize the least intrusive effective intervention that supports the service recipient in developing alternative behaviors;
 - (c) include procedures to reinforce the service recipient for interacting in more adaptive, effective ways so that the need for the challenging behavior is reduced;

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- (d) include information on the functional assessment, treatment rationale, procedures, generalization and maintenance strategies, data collection, and schedule for progress review;
 - (e) include measurable criteria for fading or removing the restricted intervention based on progress;
 - (f) clearly define all responsibilities for implementing components of the plan;
 - (g) clearly describe for staff: the description of the behavior, situations in which the behavior is likely to occur, signs and signals that occur prior to the behavior and what staff should do to reduce the likelihood of the behavior occurring, how staff should respond when the behavior occurs, what staff should do to encourage appropriate responses, what information staff should document, and crisis intervention or emergency procedures, as applicable.
- (4) The licensee ensures that the written intervention plan is reviewed and approved by appropriately constituted Behavior Support and Human Rights Committees prior to its implementation.
 - (5) The licensee ensures that staff who implement the written intervention plan are trained to competency on implementing the plan.
 - (6) The licensee ensures that staff implementation of the plan is monitored regularly and reported as part of progress notes.
 - (7) The licensee ensures that in the provision of behavior services, restraint or protective equipment is used only to protect the service recipient or others from harm and when other less intrusive methods have been ineffective or are contraindicated.
 - (8) The licensee ensures that in the provision of behavior services, the programmatic restraint or protective equipment is used only as part of any approved intervention plan for which consent has been obtained.
 - (9) The licensee does not employ the following devices or practices in the provision of behavior services:
 - (a) restraint vests, camisoles, body wraps;
 - (b) devices that are used to tie or secure a wrist or ankle to prevent movement;
 - (c) restraint chairs or chairs with devices that prevent movement;
 - (d) removal of a service recipient's mobility aids such as a wheelchair or walker;
 - (e) protective equipment that restricts or prevents movement or the normal use/functioning of the body or body part to which it is applied;
 - (f) protective equipment that impairs or inhibits visual or auditory capabilities or prevents or impairs speech or other communication modalities;
 - (g) any actions, including isolation or restraints imposed as a means of coercion, discipline, convenience or retaliation;

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- (h) corporal punishment, denial of a nutritionally balanced diet or any other procedures that may result in physical or emotional harm to the service recipient; and
- (i) time out rooms.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-20-.14 USE OF PSYCHOTROPIC MEDICATIONS IN DAY SERVICES AND FACILITIES.

- (1) The licensee obtains the following when psychotropic medications are used:
 - (a) a diagnosis that is based on a comprehensive psychiatric assessment;
 - (b) reasons for prescribing medications and specific index behaviors (target behaviors, signs, symptoms) and quality of life outcomes that will be tracked and measured to assess impact of the treatment;
 - (c) a schedule of monitoring for side effect and adverse reactions;
 - (d) a schedule of periodic review by the prescribing practitioner, including the changes in index behavior or quality of life outcomes that should prompt in-depth review by the psychiatrist.
- (2) The licensee ensures that there is informed consent from the service recipient and/or the guardian/conservator prior to utilizing psychotropic medications.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

REPEALS

Rule 0940-5-20-.01 is repealed.
Rule 0940-5-20-.02 is repealed.
Rule 0940-5-20-.03 is repealed.
Rule 0940-5-20-.04 is repealed.
Rule 0940-5-20-.05 is repealed.
Rule 0940-5-20-.06 is repealed.
Rule 0940-5-20-.07 is repealed.
Rule 0940-5-20-.08 is repealed.
Rule 0940-5-20-.09 is repealed.
Rule 0940-5-20-.10 is repealed.
Rule 0940-5-20-.11 is repealed.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

The notice of rulemaking set out herein was properly filed in the Department of State on the 26th day of July, 2005. (07-31)

RULEMAKING HEARINGS

DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES - 0940 OFFICE OF LICENSURE

There will be a hearing before the Tennessee Department of Mental Health and Developmental Disabilities, Office of Licensure to consider the promulgation of new rules and repeal of rules pursuant to T.C.A. §§ 4-4-103, 4-5-202, and 204, and 33-1-302, 305, and 309, 33-2-301 and 302, and 33-2-404. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Tennessee-B Room of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 10:00 a.m., Central Daylight Time on the 20th day of September, 2005.

Individuals with disabilities who wish to participate in these proceedings or review these filings should contact the Tennessee Department of Mental Health and Developmental Disabilities, to discuss any auxiliary aids or services needed to facilitate such participation or review. Such contact may be in person, by writing, telephone, or other means, and should be made no less than ten (10) days prior to the scheduled meeting date or the date such party intends to review such filings, to allow time to provide such aid or service. Contact the Tennessee Department of Mental Health and Developmental Disabilities ADA Coordinator, Joe Swinford, 3rd Floor, Cordell Hull Building, 425 Fifth Avenue North, Nashville, Tennessee 37243. Mr. Swinford's telephone number is (615) 532-6700; the department's TDD is (615) 532-6612. Copies of the notice are available from the Tennessee Department of Mental Health and Developmental Disabilities in alternative format upon request.

For a copy of the entire text of this notice of rulemaking hearing contact:

Glenda Rogers, Office of Licensure, Department of Mental Health and Developmental Disabilities, 425 Fifth Avenue North, Fifth Floor, Cordell Hull Building, Nashville, TN 37243-1010, (615) 532-6590.

SUBSTANCE OF PROPOSED RULES

NEW RULES

CHAPTER 0940-5-21

MINIMUM PROGRAM REQUIREMENTS FOR EARLY INTERVENTION SERVICES AND FACILITIES

CHAPTER 0940-5-32

MINIMUM PROGRAM REQUIREMENTS FOR MENTAL RETARDATION SUPPORTED LIVING SERVICES

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0940-5-32-.01	Definition	0940-5-32-.10	Medication Administration for Supported Living Services
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0940-5-21-.01 DEFINITION: EARLY INTERVENTION SERVICES AND FACILITIES – A non-residential service or facility that offer a program of training to infant and toddlers with developmental delays and their families. Early intervention services are designed to promote the development of the child and enhance the knowledge and understanding of the child by the family. Early intervention services may be provided in a variety of community settings, including the child's home or in a facility for early intervention services.

Authority: T.C.A. §§ 4-4-103; 4-5-202; §§ 33-1-101, 33-1-302, 305, and 309, §§ 33-2-301 and 302.

0940-5-21-.02 APPLICATION OF RULES.

- (1) The licensee of an early intervention service or facility must comply with the following rules:
 - (a) Applicable life safety rules for Day Care, or Business, or Educational Occupancy Classifications;
 - (b) Adequacy of Program Environment and Ancillary Services Rules when applicable;
 - (c) Minimum Program Requirements for all Program Rules, and
 - (d) Minimum Program Requirements for Early Intervention Services and Facilities.

Authority: T.C.A. §§ 4-4-103; 4-5-202; §§ 33-1-101, 33-1-302, 305, and 309, 33-2-301 and 302.

0940-5-21-.03 HEALTH, SAFETY AND WELFARE SAFEGUARDS IN EARLY INTERVENTION SERVICES AND FACILITIES.

- (1) The licensee must offer assistance to the child's family or guardian in locating qualified dental, medical, nursing, and pharmaceutical care.
- (2) The licensee must ensure that each child has a physical examination within twelve (12) months prior to admission.

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- (3) The licensee must ensure that each child receives an annual physical examination (unless less often is indicated by the child's physician) which includes routine screenings (such as vision and hearing) and laboratory examinations (such as blood work) as determined necessary by the physician and special studies where the index of suspicion is high.
- (4) The licensee develops safety and emergency plans that are specific to its facilities, services provided, transportation services and major equipment used.
- (5) The licensee develops emergency arrangements that are specific to the needs of the child.
- (6) Prior to admission, the licensee must secure proof of current immunization status.
- (7) The program must require that each child receive immunizations as required by the Department of Health unless contraindicated by a doctor's written orders.
- (8) The licensee must ensure that employees follow universal precautions that will protect the child from infectious disease.
- (9) The licensee will assist the child's family or guardian in linking with the appropriate local medical resources.
- (10) Special diets and mealtime practices as recommended by practitioners are implemented.
- (11) The licensee will assist children in assessing adaptive equipment identified in the IFSP to facilitate proper seating and alignment, body control and functional participation in home, leisure and community activities.
- (12) Equipment is monitored to determine proper fit, working order and need for repair.
- (13) Equipment storage is available to ensure adequate space for instruction to take place unobstructed by equipment that is not in use.

Authority: T.C.A. §§ 4-4-103, 4-5-202, 33-1-101, 33-1-302, 305, and 309, 33-2-301 and 302

0940-5-21-.04 PERSONNEL AND STAFFING REQUIREMENTS FOR EARLY INTERVENTION SERVICES.

- (1) The licensee must provide one (1) direct service staff member for every six (6) children present in a facility-based program.
- (2) All employees must be screened for tuberculosis according to procedures of the Tennessee Department of Health, or receive a tuberculosis skin test or chest x-ray prior to working with children. Documentation must be maintained in the employee's personnel file.
- (3) The licensee must document that the Hepatitis B vaccine is made available to all direct service employees.
- (4) Direct service employees must be provided an orientation and training regimen that includes information specific to the needs of a child prior to working with him/her.
- (5) The licensee must provide, during operating hours, at least one (1) staff member who is certified in First Aid, infant/child CPR, and the Heimlich maneuver in a center-based program.

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- (6) All staff working with children must receive training in detection, reporting, and prevention of child abuse. This training must be documented in the staff record.
- (7) All professional services must be provided by persons duly licensed or certified to practice their profession in the State of Tennessee.

Authority: T.C.A. §§ 4-4-103, 4-5-202, 33-1-101, 33-1-302, 305, and 309, 33-2-301 and 302.

0940-5-21-.05 RECORDS REQUIREMENTS FOR EARLY INTERVENTION SERVICES AND FACILITIES. Each child shall have a running record from the time of referral until the child exits the program that includes:

- (1) A recent photograph and identifying information;
- (2) The name, address, and telephone number of the child's primary caregiver;
- (3) The sources of coverage for medical care;
- (4) The names, address, and telephone number of the physician or health agency providing medical services; and
- (5) Report of medical problems, accidents, seizures, and illnesses and treatments rendered for such medical problems, accidents, seizures and illnesses while the child is in the care of the licensee.

Authority: T.C.A. §§ 4-4-103, 4-5-202, 33-1-101, 33-1-302, 305, and 309, 33-2-301 and 302.

0940-5-21-.06 PERSONAL SUPPORT PROVISIONS IN EARLY INTERVENTION SERVICES AND FACILITIES. Staff must be responsible for the implementation of the orders of a physician concerning recuperative procedures subsequent to a child's illness or injury once a child has been released to return for services and the provider determines that the placement continues to be appropriate.

Authority: T.C.A. §§ 4-4-103, 4-5-202, 33-1-101, 33-1-302, 305, and 309, 33-2-301 and 302.

0940-5-21-.07 ASSESSMENT REQUIREMENTS IN EARLY INTERVENTION SERVICES.

- (1) The following assessments must be completed prior to the development of the Individual Family Service Plan (IFSP):
 - (a) An approved assessment of the individual's current abilities, needs, and resources (currently approved by the Department of Education); and
 - (b) An appropriate eligibility statement on file with documentation of completed evaluations and assessments.
- (2) The physical and nutritional needs of the child are addressed, as needed.
- (3) Children who have eating/swallowing problems are identified and supported.

Authority: T.C.A. §§ 4-4-103, 4-5-202, 33-1-101, 33-1-302, 305, and 309, 33-2-301 and 302.

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0940-5-21-.08 INDIVIDUAL FAMILY SERVICE PLAN REQUIREMENTS FOR EARLY INTERVENTION SERVICES AND FACILITIES. The licensee must ensure that a written individual plan is provided and implemented for each child. The plan must:

- (1) be developed within forty-five (45) days of the child's initial referral for Part C-eligible children as set forth in Rule 0520-1-10-.01 of the Rules of the State Board of Education, or within forty-five (45) days of admission;
- (2) be developed by relevant persons, including the parent(s)/guardian(s);
- (3) identify supports and services to be provided;
- (4) have written approval by the parent(s)/guardian(s); and
- (5) contain a Transition Plan to Part B or other appropriate services developed no later than the child's second birthday or immediately after admission for a child older than two years.

Authority: T.C.A. §§ 4-4-103, 4-5-202, 33-1-101, 33-1-302, 305, and 309, 33-2-301 and 302.

0940-5-21-.09 INDIVIDUAL FAMILY SERVICE PLAN MONITORING FOR EARLY INTERVENTION SERVICES AND FACILITIES.

- (1) Progress notes which are shared with the parents that detail progress or changes occurring with the Individual Family Service Plan (IFSP) must be documented monthly.
- (2) The individual family service plan must be reviewed every six months and revised as needed.

Authority: T.C.A. §§ 4-4-103, 4-5-202, 33-1-101, 33-1-302, 305, and 309, 33-2-301 and 302.

0940-5-21-.10 REQUIREMENTS FOR POSITIVE BEHAVIOR INTERVENTIONS IN EARLY INTERVENTION SERVICES.

- (1) Licensee should utilize positive methods for supporting a child's social and emotional development. Praise and encouragement of good behavior must be used instead of focusing upon unacceptable behavior only.
- (2) Licensee should utilize developmentally appropriate behavior practices that are reasonable and appropriate and in terms the child can understand. Techniques that are shaming, humiliating, frightening or injurious to children must not be used.
- (3) Caregivers must provide activities and have behavioral expectations that are consistent with the child's age, attention span and skill level.
- (4) Behavior interventions may only be employed as an integral part of the Individual Family Service Plan (IFSP) and with the review of the IFSP team.

Authority: T.C.A. §§ 4-4-103, 4-5-202, 33-1-101, 33-1-302, 305, and 309, 33-2-301 and 302.

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0940-5-32-.01 DEFINITION: MENTAL RETARDATION SUPPORTED LIVING SERVICES - A service entity which provides support and assistance to individuals with mental retardation who live in their own homes or apartments but require such staff support and assistance to reside in such housing situations. Service entity staff provides support and assistance on a regular basis in accordance with the needs of the individual(s) living in the home. No more than three (3) persons receiving services shall reside in the home. The service entity delivering the support is licensed rather than the home of the individuals receiving the support.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-32-.02 APPLICATION OF RULES.

The licensee for Supported Living Services must comply with the following rules:

- (a) Applicable life safety rules for Business Occupancy Classification;
- (b) Minimum Program Requirements for All Program Rules;
- (c) Minimum Program Requirements for Mental Retardation Supported Living Services;
- (d) Applicable rules for services provided to (1) one or more mobile, non-ambulatory person(s).

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-32-.03 HEALTH, SAFETY AND WELFARE SAFEGUARDS FOR SUPPORTED LIVING SERVICES.

- (1) The licensee must ensure that individuals are assisted in locating qualified dental, medical, nursing and pharmaceutical care including care for emergencies.
- (2) The licensee must ensure that each service recipient receives an annual physical examination (unless less often is indicated by the service recipient's physician) which includes routine screenings (such as vision and hearing) and laboratory examinations (such as Pap smear, mammogram, prostate screening, and blood work) as determined necessary by the physician and special studies where the index of suspicion is high.
- (3) The licensee must ensure that employees practice infection control procedures that will protect individuals from infectious diseases.
- (4) The licensee must ensure that appropriate corrective actions have been taken in response to substantiated abuse or neglect.
- (5) The licensee must ensure that support staff in each dwelling comply with the following:
 - (a) All staff must be trained to assist each individual in evacuation from the home in three (3) minutes or less. Training must be according to the needs of the individual being assisted;
 - (b) Evacuation procedures must be sufficient so that it is not necessary for a staff person to re-enter the building after once leaving;

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- (c) A risk assessment must be completed for each individual within thirty (30) days of enrollment or moving into the home;
 - (d) The risk assessment must be repeated when the individual's circumstances change;
 - (e) Ambulatory individuals who cannot evacuate independently within three (3) minutes must receive training needed to improve his or her ability to evacuate the home more independently. Individuals with a documented inability to respond to training need not receive such training; and,
 - (f) Document fire-safety drills, which must be conducted under varying conditions, and each shift, when applicable, must hold one (1) per quarter.
- (6) The licensee must ensure that the home of each individual receiving support complies with the following requirements:
- (a) Provide at least two hundred (200) square feet, gross, of occupiable space per individual, with eighty (80) square feet per individual bedroom space for single occupancy or sixty (60) square feet per individual bedroom space for multiple occupancy;
 - (b) Maintain proper storage and safeguards for all flammable materials;
 - (c) Unvented gas heaters or portable electric heaters must not be used;
- Use extension cords only on a limited basis and under emergency conditions;
- (e) Provide at least one smoke detector in the home that is hardwired into the home's electrical system;
 - (f) Provide operable, type 2A-10B, C multipurpose fire extinguishers in a fixed location and readily accessible for use in the home, and document that all fire extinguishers are properly maintained and services;
 - (g) Provide two (2) alternative means of escape in each dwelling e.g. front door and bedroom window;
 - (h) Bedrooms with windows that are operable from the inside without the use of special keys, tools or knowledge;
 - (i) Bedroom windows must provide a clear opening of not less than twenty (20) inches in width, twenty-four (24) inches in height, and five and seven-tenths (5.7) square feet in area, and the bottom of the opening is not more than forty-four (44) inches from the floor;
 - (j) Specify areas where smoking is permitted; smoking in bedrooms must not be allowed;
 - (k) Individuals who use ambulation aids cannot be located above or below the ground floor.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

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0940-5-32-.04 GENERAL ENVIRONMENTAL REQUIREMENTS FOR HOMES RECEIVING SUPPORTED LIVING SERVICES.

- (1) The licensee must ensure that the home of each individual receiving support complies with the following requirements:
 - (a) Each home must be maintained in a safe manner and a continuing effort made to eliminate potential hazards.
 - (b) Each home must be maintained in a sanitary and clean condition, free from all accumulation of dirt and rubbish, well vented, and free from foul, stale or musty odors.
 - (c) Each home must be kept free of rats and other rodents.
 - (d) Support staff must ensure that housekeeping practices and standards are maintained which will ensure the eradication of flies, roaches, and other vermin.
 - (e) All interior and exterior stairs and steps must be equipped with security and safely installed handrails when there is more than three (3) stair steps in a row.
 - (f) All interior and exterior stairways, halls, porches, walkways and all other means of egress and areas of exit discharge must be maintained free of any obstacles, including furniture or other stored items.
 - (g) A heating system must be provided which is capable of maintaining a minimum of sixty-eight (68) degrees Fahrenheit and a comfortable humidity level at all times within the home.
 - (h) A cooling, natural ventilation or air conditioning system must be provided which is capable of maintaining a maximum temperature of eighty (80) degrees Fahrenheit and a comfortable humidity level at all times within the home.
 - (i) A telephone system must be provided which is capable of ensuring prompt notification in case of emergencies and which is capable of meeting the needs of service recipients.
 - (j) Emergency telephone numbers must be available for the most local available agencies for fire protection, police or sheriff, ambulance, or medical intervention, poison control, and person(s) providing support.
 - (k) Drinking water must be provided from a source approved by the Tennessee Department of Health.
 - (l) A system for disposal of sewage must be provided which is connected to a public sewage system or which is connected to a private sewage system (septic tank and field system) which has the approval of the local public health agency having jurisdiction.
- (2) The licensee must ensure that each individual is provided with the following:
 - (a) A bed with mattress, and springs, in good repair, intended for the individual's convenience and comfort;
 - (b) Bedding such as blankets, linens, and pillows based on the individual's choice or health reasons, which are clean and in good repair.

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- (c) Adequate space for clothing for each individual residing in the home i.e.: dresser or chest of drawers;
- (d) Closet or wardrobe space which is adequate for hanging storage;
- (e) Access to a mirror;
- (f) Each bedroom must have window coverings for privacy, according to the individual's choice;
- (g) Bathroom(s) must be provided within each home which are equipped with private toilet(s), lavatory with hot water, private tub or shower with hot water, and tub and shower floor surface equipped to be slip-resistant.
- (h) Sanitary soap and towels provided at each lavatory; and sanitary toilet paper provided at each toilet, unless a person's individual support plan (ISP) states otherwise.
- (i) A dining area and living area in each home which are appropriately furnished in good repair, and sufficient for meeting the needs of the individuals.

Authority: T.C.A. §§ 4-4-103; -5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-32-.05 FOOD SERVICES AND NUTRITION REQUIREMENTS FOR SUPPORTED LIVING SERVICES.

- (1) The licensee must ensure that support staff in each dwelling comply with the following:
 - (a) Food and nutrition must be provided in as normal a fashion as possible.
 - (b) Food must be served in sufficient quantity, at correct temperatures, and in a form consistent with United States Dietary Standards or in accordance with special requirements noted in ISP.
 - (c) Individuals, including those with physical handicaps, must be allowed to eat meals at a table in a dining area unless contra-indicated for medical reasons. Provisions must be made for following special diets for when such diets are prescribed for medical or health reasons, and encouragement given to individuals to follow such special diets.
 - (d) Provide appropriate equipment and utensils for cooking food and serving meals. Such equipment and utensils must be in good repair, washed after each use.
 - (e) Food requiring cold storage must be maintained at a temperature of forty-five (45) degrees Fahrenheit or below and food requiring frozen storage must be maintained at a temperature of ten (10) degrees Fahrenheit or below.
 - (f) Store all dry food and goods in a manner to prevent possible contamination, and stored a minimum of six (6) inches above the floor.
 - (g) Store garbage (food waste) in secure containers with tight-fitting lids and liner. Garbage (food waste) containers must be emptied from the home into secure containers located outside the home.

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Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-32-.06 TRANSPORTATION SERVICES FOR INDIVIDUALS IN SUPPORTED LIVING SERVICES.

- (1) All staff providing transportation must possess an appropriate driver's license from the Tennessee Department of Safety, and documentation of such license must be maintained in the agency's records.;
- (2) All agency-owned and staff-owned vehicles used to transport individuals must be adequately covered by vehicle liability insurance for personal injury to occupants of the vehicle, and documentation of such insurance must be maintained in the agency's records.
- (3) Appropriate safety restraints must be used as required by state and federal law.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-32-.07 SPECIAL REQUIREMENT FOR HOMES WITH INDIVIDUALS WITH VISION LOSS. The licensee must ensure the design and placement of furnishings are consistent, free of special hazards, and made known to the service recipient especially when changes occur in the home's design or placement of furnishings.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-32-.08 PERSONNEL AND STAFFING REQUIREMENTS FOR SUPPORTED LIVING SERVICES.

- (1) The licensee must ensure that appropriate support and assistance are provided in accordance with the needs of the individual(s) living in the home.
- (2) Support staff must be available on call to individuals living in the home on a twenty-four-(24) hour per day basis.
- (3) Support staff must be provided with a basic orientation in the proper management of individuals with seizures prior to being assigned to work with those individuals.
- (4) The licensee must ensure that support staff are trained in First Aid, Cardiopulmonary Resuscitation (CPR), and the Heimlich maneuver.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

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0940-5-32-.09 RECORD REQUIREMENTS FOR SUPPORTED LIVING SERVICES.

- (1) The licensee must ensure that each individual's record contains the following information:
 - (a) A recent photograph of the individual and identifying information about the individual;
 - (b) The individual's social security number;
 - (c) The individual's legal competency status, including the name of the guardian/conservator, if applicable;
 - (d) The individual's source of financial support, including social security, veteran's benefit and insurance;
 - (e) The individual's source of coverage for medical care;
 - (f) The name, address and telephone number of the physician or health agency providing medical services;
 - (g) Documentation of the use of restrictive behavior-management techniques;
 - (h) Written accounts of all monies received and disbursed on behalf of the individual;
 - (i) Report of significant behavior incidents and of action taken;
 - (j) Reports of medical problems, accidents, seizures and illnesses and treatments rendered for such medical problems, accidents, seizures and illnesses as they occur;

Authority: *T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.*

0940-5-32-.10 MEDICATION ADMINISTRATION IN SUPPORTED LIVING SERVICES.

- (1) When medications are taken by individuals with the assistance of support staff, the licensee must ensure that:
 - (a) The individual's ability and training are considered;
 - (b) Ensure that if service recipients are not capable of self-administration of medication, the medication is only administered by personnel who are licensed or certified to administer medication in the State of Tennessee;
 - (c) Prescription medications are taken only by individual for whom they are prescribed; and in accordance with the directions of the physician;
 - (d) Provide storage for medications in a locked container that ensures proper conditions of security and sanitation and prevents accessibility by any unauthorized person;
 - (e) Discontinued and outdated medications and containers with worn, illegible or missing labels are disposal;

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- (f) All medication errors, reactions or suspected overmedication are report to the practitioner who prescribed the medication; and
- (g) Maintain documentation of all prescription medications taken with assistant by each individual supported in the home, including the name of the medication, name of prescribing physician, date prescribed, purpose, dosage, frequency and side effects.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-32-.11 DAY ACTIVITY PROVISIONS FOR INDIVIDUALS RECEIVING SUPPORTED LIVING SERVICES.

- (1) The licensee must ensure that daily activities are provided or procured in accordance with the age level, interests, and abilities of the individual as specified; in the individual support plan. Such daily activities may include, but are not limited to, part-time and full-time employment, attendance at a senior citizens program, and community habilitative activities.
- (2) If the individual attends a school or day program provided outside of the licensed service, the licensee must ensure that staff participate with the school personnel in developing an individual education plan or with the day programs staff in developing an individual plan, as appropriate.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-32-.12 ASSESSMENT REQUIREMENTS FOR PERSONS RECEIVING SUPPORTED LIVING SERVICES. The following assessments must be completed prior to developing the individual support plan:

- (1) An assessment of current abilities and preferences; and
- (2) A review o relevant medical, medication, and health information.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-32-.13 INDIVIDUAL SUPPORT PLAN REQUIREMENTS FOR SUPPORTED LIVING SERVICES. The licensee must ensure that a written support plan is implemented for each individual. The individual support plan must meet all the following requirements:

- (1) Be developed within 30 days after the initiation of services;
- (2) Be developed by relevant persons, including the individual served;
- (3) Be approved by the individual or guardian;
- (4) Address abilities, needs and preferences; and
- (5) Identify supports that will be provided to the individual and the person or entity that will provide the supports.

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Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-32-.14 INDIVIDUAL SUPPORT PLAN MONITORING FOR SUPPORTED LIVING SERVICES.

- (1) Support summaries are documented at least quarterly; and
- (2) The individual support plan must be reviewed at least annually and revised as indicated.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-32-.15 SUPPORTIVE SERVICES FOR INDIVIDUALS RECEIVING SUPPORTED LIVING SERVICES. The licensee must ensure that the following support services are provided for individuals as needed:

- (1) Transportation or assistance with transportation for non-routine events and appointments;
- (2) Liaison for making appointments and obtaining consultation with professional services;
- (3) Assistance to individuals in the utilization of professional, social, and community services, and assistance in the referral process in making appointments for such services;
- (4) Assistance in the use and protection of money; and
- (5) Assistance in applying for financial benefits for which the individual may be eligible.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-32-.16 REQUIREMENTS FOR THE USE OF RESTRICTED BEHAVIOR INTERVENTIONS FOR SUPPORTED LIVING SERVICES.

- (1) The licensee must ensure that restricted behavior interventions are not provided until unrestricted interventions have been systematically tried or considered and have been determined to be inappropriate or otherwise contraindicated.
- (2) The licensee must ensure that restricted behavior interventions are only provided through an approved written intervention plan.
- (3) If restricted interventions are provided, the written intervention plan must:
 - (a) be based upon a functional assessment;
 - (b) utilize the least intrusive effective intervention that supports the service recipient in developing alternative behaviors;
 - (c) include procedures to reinforce the service recipient for interacting in more adaptive, effective ways so that the need for the challenging behavior is reduced;

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- (d) include information on the functional assessment, treatment rationale, procedures, generalization and maintenance strategies, data collection, and schedule for progress review;
 - (e) include measurable criteria for fading or removing the restricted intervention based on progress;
 - (f) clearly define all responsibilities for implementing components of the plan;
 - (g) clearly describe for staff: the description of the behavior, situations in which the behavior is likely to occur, signs and signals that occur prior to the behavior and what staff should do to reduce the likelihood of the behavior occurring, how staff should respond when the behavior occurs, what staff should do to encourage appropriate responses, what information staff should document, and crisis intervention or emergency procedures, as applicable.
- (4) The licensee ensures that the written intervention plan is reviewed and approved by appropriately constituted Behavior Support and Human Rights Committees prior to its implementation.
 - (5) The licensee ensures that staff who implement the written intervention plan are trained to competency on implementing the plan.
 - (6) The licensee ensures that staff implementation of the plan is monitored regularly and reported as part of progress notes.
 - (7) The licensee ensures that in the provision of behavior services, restraint or protective equipment is used only to protect the service recipient or others from harm and when other less intrusive methods have been ineffective or are contraindicated.
 - (8) The licensee ensures that in the provision of behavior services, the programmatic restraint or protective equipment is used only as part of any approved intervention plan for which consent has been obtained.
 - (9) The licensee does not employ the following devices or practices in the provision of behavior services:
 - (a) restraint vests, camisoles, body wraps;
 - (b) devices that are used to tie or secure a wrist or ankle to prevent movement;
 - (c) restraint chairs or chairs with devices that prevent movement;
 - (d) removal of a service recipient's mobility aids such as a wheelchair or walker;
 - (e) protective equipment that restricts or prevents movement or the normal use/functioning of the body or body part to which it is applied;
 - (f) protective equipment that impairs or inhibits visual or auditory capabilities or prevents or impairs speech or other communication modalities;
 - (g) any actions, including isolation or restraints imposed as a means of coercion, discipline, convenience or retaliation;
 - (h) corporal punishment, denial of a nutritionally balanced diet or any other procedures that may result in physical or emotional harm to the service recipient; and

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- (i) time out rooms.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

0940-5-32-.17 USE OF PSYCHOTROPIC MEDICATIONS IN SUPPORTED LIVING SERVICES.

- (1) The licensee obtains the following when psychotropic medications are used:
 - (a) a diagnosis that is based on a comprehensive psychiatric assessment; and
 - (b) reasons for prescribing medications, a schedule of monitoring for side effect and adverse reactions.
- (2) The licensee ensures that there is informed consent from the service recipient and/or the guardian/conservator prior to utilizing psychotropic medications.

Authority: T.C.A. §§ 4-4-103; 4-5-202 and 204; and 33-1-302, 305, and 309 and 33-2-301 and 302 and 33-2-404.

REPEALS

Rules 0940-5-21-.01 through 0940-5-32-.11 are repealed.

Authority: T.C.A. §§ 4-4-103, 4-5-202 and 204, 33-1-101, 33-1-302, 305, 309 and 33-2-301 and 302, and 33-2-404.

The notice of rulemaking set out herein was properly filed in the Department of State on the 26th day of July, 2005. (07-33)

RULEMAKING HEARINGS

BOARD OF SOCIAL WORKER CERTIFICATION AND LICENSURE - 1365

There will be a hearing before the Tennessee Board of Social Worker Certification and Licensure to consider the promulgation amendments to rules and a new rule pursuant to T.C.A. §§ 4-5-202, 4-5-204, and 63-23-108. The hearing will be conducted in the manner prescribed by the Uniform Administrative Procedures Act, Tennessee Code Annotated, Section 4-5-204 and will take place in the Tennessee Room of the Cordell Hull Building located at 425 Fifth Avenue North, Nashville, TN at 2:30 p.m. (CDT) on the 28th day of September, 2005.

Any individuals with disabilities who wish to participate in these proceedings (review these filings) should contact the Department of Health, Division of Health Related Boards to discuss any auxiliary aids or services needed to facilitate such participation or review. Such initial contact may be made no less than ten (10) days prior to the scheduled meeting date (the date such party intends to review such filings), to allow time for the Division to determine how it may reasonably provide such aid or service. Initial contact may be made with the ADA Coordinator at the Division of Health Related Boards, First Floor, Cordell Hull Building, 425 Fifth Avenue North, Nashville, TN 37247-1010, (615) 532-4397.

For a copy of the entire text of this notice of rulemaking hearing contact: Jerry Kosten, Regulations Manager, Division of Health Related Boards, 425 Fifth Avenue North, First Floor, Cordell Hull Building, Nashville, TN 37247-1010, (615) 532-4397.

SUBSTANCE OF PROPOSED RULES

AMENDMENTS

1365-1-.03, Necessity of Licensure, is amended by numbering the present language of this rule as paragraph (1), and is further amended by adding the following language as new paragraph (2):

(2) Use of Titles -

- (a) Any person who possesses a valid, unsuspended and unrevoked certificate issued by the Board has the right to use the title and/or acronym "Certified Master Social Worker (C.M.S.W.)," as defined in T.C.A. §§ 63-23-102.
- (b) Any person who possesses a valid, unsuspended and unrevoked license issued by the Board has the right to use the title and/or acronym "Licensed Clinical Social Worker (L.C.S.W.)," as defined in T.C.A. §§ 63-23-103.
- (c) Violation of this rule or T.C.A. §§ 63-23-106 and 63-23-111 regarding use of titles shall constitute unethical conduct and subject the licensee or certificate holder to disciplinary action.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-23-102, 63-23-103, 63-23-106, 63-23-108, and Public Chapters 467 and 469 of the Public Acts of 2005.

Rule 1365-1-.19 Board Meetings, Officers, Consultant, and Records is amended by deleting the catchline in its entirety and substituting instead the following language, and is further amended by adding the following language as new paragraph (8), so that as amended, the new catchline and the new paragraph (8) shall read:

RULEMAKING HEARINGS

1365-1-.19 BOARD MEETINGS, OFFICERS, CONSULTANT, RECORDS, AND SCREENING PANELS.

- (8) Screening Panels - The Board adopts, as if fully set out herein, rule 1200-10-1-.13, of the Division of Health Related Boards and as it may from time to time be amended, as its rule governing the screening panel process.

Authority: T.C.A. §§ 4-5-107, 4-5-202, 4-5-204, 63-1-138, 63-23-106, 63-23-108, and Public Chapter 234 of the Public Acts of 2005.

NEW RULE

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1365-1-.23 Advertising

1365-1-.23 ADVERTISING.

- (1) Definitions
 - (a) Advertising - Includes but is not limited to paid or unpaid public statements, brochures, printed matter, directory listings, personal resumes or curricula vitae, interviews or comments for use in media, statements in legal proceedings, lectures and public oral presentations, and published materials.
 - (b) Certificate Holder - Any person holding a certificate to practice as a Certified Master Social Worker (C.M.S.W.). Where applicable this shall include partnerships and/or corporations.
 - (c) Licensee - Any person holding a license to practice as a Licensed Clinical Social Worker (L.C.S.W.) in the State of Tennessee. Where applicable this shall include partnerships and/or corporations.
 - (d) Material Fact - Any fact which an ordinary reasonable and prudent person would need to know or rely upon in order to make an informed decision concerning the choice of practitioners to serve his or her particular needs.
- (2) Advertising Content. The following acts or omissions in the context of advertisement by any licensee or certificate holder shall constitute unethical conduct, and subject the licensee or certificate holder to disciplinary action pursuant to T.C.A. § 63-23-106 (a) (5):
 - (a) Claims that the services performed, personnel employed, or office equipment used are professionally superior to that which is ordinarily performed, employed, or used, or that convey the message that one licensee or certificate holder is better than another when superiority of services, personnel, materials or equipment cannot be substantiated.
 - (b) The misleading use of an unearned degree.
 - (c) Promotion of professional services which the licensee or certificate holder knows or should know is beyond the licensee's ability to perform.
 - (d) Techniques of communication which intimidate, exert undue pressure or undue influence over a prospective client.

RULEMAKING HEARINGS

- (e) Any appeals to an individual's anxiety in an excessive or unfair manner.
 - (f) The use of any personal testimonial attesting to a quality of competency of a service or treatment offered by a licensee or certificate holder that is not reasonably verifiable.
 - (g) Utilization of any statistical data or other information based on past performances for prediction of future services, which creates an unjustified expectation about results that the licensee or certificate holder can achieve.
 - (h) The communication of personal identifiable facts, data, or information about a patient without first obtaining patient consent.
 - (i) Any misrepresentation of a material fact.
 - (j) The knowing suppression, omission or concealment of any materials fact or law without which the advertisement would be deceptive or misleading.
 - (k) Misrepresentation of credentials, training, experience, or ability.
 - (l) Failure to include the corporation, partnership or individual name, address, and telephone number of licensees and certificate holders in any advertisement. Any corporation, partnership or association which advertises by use of a trade name or otherwise fails to list all licensees and certificate holders practicing at a particular location shall:
 - 1. Upon request provide a list of all licensees and certificate holders practicing at that location; and
 - 2. Maintain and conspicuously display a directory listing all licensees and certificate holders practicing at that location.
 - (m) Failure to disclose the fact of giving compensation or anything of value to representative of the press, radio, television or other communicative medium in anticipation of or in return for any advertisement (for example, newspaper article) unless the nature, format or medium of such advertisement make the fact of compensation apparent.
 - (n) After thirty (30) days of the licensee's departure, the use of the name of any licensee or certificate holder formerly practicing at or associated with any advertised location or on office signs or buildings. This rule shall not apply in the case of a retired or deceased former associate who practiced in association with one or more of the present occupants if the status of the former associate is disclosed in any advertisement or sign.
 - (o) Stating or implying that a certain licensee or certificate holder provides all services when any such services are performed by another licensee.
 - (p) Directly or indirectly offering, giving, receiving, or agreeing to receive any fee or other consideration to or from a third party for the referral of a patient in connection with the performance of professional services.
 - (q) Making false, deceptive, misleading or fraudulent statements regarding fees.
- (3) Advertising Records and Responsibility

RULEMAKING HEARINGS

- (a) Each licensee or certificate holder who is a principal partner, or officer of a firm or entity identified in any advertisement, is jointly and severally responsible for the form and content of any advertisement. This provision shall also include any licensed or certified professional employees acting as an agent of such firm or entity.
 - (b) Any and all advertisements are presumed to have been approved by the licensee or certificate holder named therein.
 - (c) A recording of every advertisement communicated by electronic media, and a copy of every advertisement communicated by print media, and a copy of any other form of advertisement shall be retained by the licensee or certificate holder for a period of two (2) years from the last date of broadcast or publication and be made available for review upon request by the Board or its designee.
 - (d) At the time any type of advertisement is placed, the licensee or certificate holder must possess and rely upon information which, when produced, would substantiate the truthfulness of any assertion, omission or representation of material fact set forth in the advertisement or public information.
- (4) Advertising Conduct
- (a) Licensees or certificate holders who engage others to create or place public statements that promote their professional practice, products, or activities retain professional responsibility for such statements.
 - (b) If licensees or certificate holders learn of deceptive statements about their work made by others, licensees or certificate holders make reasonable efforts to correct such statements.
 - (d) Licensees or certificate holders do not compensate employees of press, radio, television or other communication media in return for publicity in a news item.
 - (e) A paid advertisement relating to the licensee's or certificate holders' activities must be identified as such, unless it is already apparent from the context.
- (5) Severability. It is hereby declared that the sections, clauses, sentences and part of these rules are severable, are not matters of mutual essential inducement, and any of them shall be rescinded if these rules would otherwise be unconstitutional or ineffective. If any one or more sections, clauses, sentences or parts shall for any reason be questioned in court, and shall be adjudged unconstitutional or invalid, such judgment shall not affect, impair or invalidate the remaining provisions thereof, but shall be confined in its operation to the specific provision or provisions so held unconstitutional or invalid, and the inapplicability or invalidity of any section, clause, sentence or part in any one or more instance shall not be taken to affect or prejudice in any way its applicability or validity in any other instance.

Authority: T.C.A. §§ 4-5-202, 4-5-204, 63-23-103, 63-23-106, 63-23-108, and Public Chapter 467 of the Public Acts of 2005.

The notice of rulemaking set out herein was properly filed in the Department of State on the 22nd day of July, 2005. (07-24)

WILDLIFE PROCLAMATIONS

TENNESSEE WILDLIFE RESOURCES COMMISSION - 1660

PROCLAMATION 05-19 ESTABLISHING COVE MOUNTAIN WILDLIFE MANAGEMENT AREA

Pursuant to the authority granted by Title 70, Tennessee Code Annotated, the Sections 70-1-302 and 70-5-101 thereof, the Tennessee Wildlife Resources Commission hereby proclaims the following area to be known as Cove Mountain Wildlife Management Area.

Lands and waters in Sevier County, lying adjacent to or near the Great Smoky Mountains National Park, and owned or leased by the Tennessee Wildlife Resources Agency, as posted. A more complete description may be found on file in the Tennessee Wildlife Resources Agency office, Nashville, Tennessee.

This proclamation repeals Proclamation 87-15, dated September 3, 1987, in its entirety.

Proclamation No. 05-19 received and recorded this 25th day of July, 2005. (07-28)

WILDLIFE PROCLAMATIONS

WILDLIFE RESOURCES COMMISSION - 1660

PROCLAMATION 05-20

PROCLAIMING BEAR HOLLOW MOUNTAIN WILDLIFE MANAGEMENT AREA

Pursuant to the authority granted by Title 70, Tennessee Code Annotated, Sections 70-1-206 and 70-5-101, the Tennessee Wildlife Resources Commission hereby proclaims the following area as a wildlife management area to be known as the Bear Hollow Mountain Wildlife Management Area:

Those lands in Franklin County, Tennessee; as described in Deed Book 324, page 216, consisting of approximately 9000 acres in the Bear Hollow Mountain and Walls of Jericho areas along the Tennessee and Alabama border.

The boundary line is posted with "Wildlife Management Area" signs. A more complete description may be found on file in the Real Estate Division office of Tennessee Wildlife Resources Agency, Nashville, Tennessee.

Proclamation No. 05-20 received and recorded this 25th day of July, 2005. (07-28)

WILDLIFE PROCLAMATIONS

Tennessee Wildlife Resources Commission - 1660

PROCLAMATION 05-21 AMENDING PROCLAMATION 05-14 - WILDLIFE MANAGEMENT AREAS HUNTING SEASONS, LIMITS AND MISCELLANEOUS REGULATIONS

Pursuant to the authority granted by Tennessee Code Annotated Sections 70-4-107 and 70-5-108, the Tennessee Wildlife Resources Commission hereby amends proclamation 05-14 as follows:

Section II

By inserting Kyles Ford WMA in the 1st paragraph that lists WMA's open with the statewide season so that as amended the paragraph shall read:

"The following areas or units are open to hunting as set out in the statewide seasons and bag limits except as noted:

Alpine Mountain	Keyes-Harrison
Arnold Hollow (17)	Kyles Ford
Barkley Unit I (6)(12)(17)(21)(27)(33)	Lick Creek (17)(21)
Barkley Unit II (17)(21)	Long Pond (11)(17)
Bean Switch Refuge (10)(11)(17)(18)(21)	Maple Springs (17)
Beaver Dam Creek (17)	Mingo Swamp (17)
Big Sandy (5)(6)(12)(17)(21)	MTSU (17)
Browntown (17)	Mt. Roosevelt
Camden Unit I (1)(6)(12)(17)(21)(27)	New Hope (17)(21)
Camden Unit II (12)(17)(21)	Normandy (17)
Cedar Hill Swamp (8)(17)	Owl Hollow Mill (17)(31)
Chickasaw State Forest (17)(21)(25)(29)	Pickett State Forest
Cold Creek (17)(30)	Shelton Ferry (17)(32)
Cove Creek (3)(17)(9)	Standing Stone State Forest (2)(15)
Cove Mountain (3)(22)(23)	Tie Camp (17)
Cypress Pond Refuge (10)(11)(17)	Tigrett (1)(17)(21)
Doe Mountain (3)(14)(17)(24)	Tumbleweed (17)
Harmon Creek (17)(21)	Watts Bar (7)(16)
Hick Hill (17)	West Sandy (1)(6)(12)(17)(20) (21)(28)
Hop-In Refuge (10)(11)(17)(18)(21)	White Lake Refuge (10)(11)(17)(18)
Horns Bluff Refuge (8)(10)(17)	White Oak (4)(13)(17)(19)(21)(26)(29)"
Jarrell Switch Refuge (10)(11)(17)	

Section II is further amended by inserting the following WMA prior to Black Bayou Refuge:

Bear Hollow Mountain

Dove, Squirrel, Grouse, Quail,
Rabbit, Raccoon, Opossum,
Woodcock

Same as the statewide seasons.
hunting with dogs allowed during the
spring squirrel season.

Deer/Turkey (Fall Seasons)

Same as statewide seasons and bag limits
except no more than 1 deer may be harvested
per day. All deer hunting ends after December
18.

WILDLIFE PROCLAMATIONS

Spring Turkey (Youth)	One 2-day hunt. Mar. 25-26. No hunter quota. One turkey, either-sex.
Spring Turkey	Seven 3-day hunts. Apr. 1-3, 7-9, 14-16, 21-23, 28-30, May 5-7, 12-14. No hunter quota. WMA bag limit applies to these hunts.
ATVs	ATVs and other types of ORVs are prohibited.

Section II is further amended:

By inserting Bear Hollow Mountain and Kyles Ford in the list of WMAs open to trapping as set out in the statewide season so that the list shall read:

AEDC	Cold Creek	New Hope
Alpine Mountain	Cordell Hull	Normandy
Arnold Hollow	Cove Creek	Obion River
Bark Camp Barrens	Doe Mountain	Old Hickory
Barkley Unit I (1)	Ernest Rice, Sr.	Owl Hollow Mill
Barkley Unit II	Foothills	Pea Ridge
Bear Hollow Mountain	Harmon Creek	Percy Priest (Unit II)
Beaver dam Creek	Haynes Bottom	Pickett State Forest
Big Sandy (1)	Hick Hill	Prentice Cooper State Forest (7)
Bridgestone/Firestone (7)	Hickory Flats	Rankin
Browntown	Kyles Ford	Reelfoot (15)
Buffalo Springs	Laurel Hill (5)	Royal Blue (11)
Camden Unit I (1)	LBL	Shelton Ferry
Camden Unit II	Lick Creek	Standing Stone State Forest (4)
Catoosa (6)	Lick Creek Bottoms	Sundquist
Cedar Hill Swamp	Long Pond	Tie Camp
Cheatham (5)	Moss Island	Tigrett
Cheatham Lake	Maple Springs	John Tully
Cherokee-North Unit	Mingo Swamp	Tumbleweed
Cherokee-South Unit (12)	Mt. Roosevelt	Watts Bar (9)
Chickamauga (8)	MTSU	West Sandy (1)
Chickasaw State Forest	Natchez Trace State Forest (2)	White Oak
Chuck Swan State Forest (13)	Meeman-Shelby Forest State Park and Natural Area (10)	Wolf River
C.M. Gooch (3)		Yanahli

Proclamation No. 05-21 received and recorded this 25th day of July, 2005. (07-30)



CERTIFICATE OF APPROVAL

As provided by T.C.A., Title 4, Chapter 5, I hereby certify that to the best of my knowledge, this issue of the Tennessee Administrative Register contains all documents required to be published that were filed with the Department of State in the period beginning July 1, 2005 and ending July 29, 2005.

A handwritten signature in black ink, reading 'Riley C. Darnell'.

RILEY C. DARNELL
Secretary of State